THE SECRETARY OF HEALTH AND HUMAN SERVICES
WASHINGTON, D.C. 20201

JAN 7 1994

The Honorable Albert Gore, Jr.
President of the Senate
Washington, D.C. 20510

Dear Mr. President:

I am pleased to provide this report consistent with section 1848 (g)(6) of the Social Security Act (the Act), as added by the Omnibus Budget Reconciliation Act of 1989 (OBRA 89). That section requires me to report annually on participation, assignment, and extra billing in the Medicare program. This is the second annual report submitted pursuant to that statutory provision.

Pursuant to our monitoring responsibility under the Act, we reviewed data to determine whether financial liability increased for Medicare beneficiaries under the first year of the Medicare physician fee schedule. We are pleased to report that, during the fee schedule's first year (i.e., during 1992), Medicare beneficiaries experienced few, if any, increases in their overall financial liability. In fact, the contrary is true. In 1992, Medicare beneficiary liability decreased on two fronts. There was a smaller proportion of dollars billed on an unassigned basis (i.e., a 17.2 percent decrease), and for the unassigned dollars remaining, the extra billing rate decreased.

From 1991 to 1992, the percent of Medicare allowed charges billed on an assignment-related basis increased from 83.6 percent to 86.5 percent. During that same period, there was also a 7.3 percent increase in the proportion of charges billed by participating physicians and practitioners.

Extra billing is the amount by which submitted charges on unassigned claims exceed allowed charges. During 1992, extra billing dropped to 22.8 percent. This was a 23.5 percent reduction from the 1991 rate. Similarly, the percentage of physicians who sign Medicare participation agreements continued to increase.

In summary, we have found no significant decreases in the assignment rate or proportions of charges billed by participating physicians. Nor have we found significant increases in extra billing rates. Therefore, no plan to address such problems is being submitted with this report.

I am also sending a copy of this report to the Speaker of the House of Representatives.

Sincerely,

Donna E. Shalala

Donna E. Shalala

Enclosure

THE SECRETARY OF HEALTH AND HUMAN SERVICES
WASHINGTON, D.C. 20201

JAN 7 1994

The Honorable Thomas S. Foley
Speaker of the House of Representatives
Washington, D.C. 20515

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Donna E. Shalala

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Enclosure

cc: *Louisa Buatti*
Stan Weintraub
Janet McNair ✓

1993 ANNUAL REPORT TO CONGRESS

Changes in Physician Participation, Assignment, and Extra Billing in the Medicare Program During Calendar Year 1992

Donna E. Shalala
Secretary of Health and Human Services
1994

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Table 15. 1993 Physician/Practitioner Enrollment, By Specialty

EXECUTIVE SUMMARY

Medicare beneficiaries experienced few, if any, overall increases in their financial liability in 1992, i.e., during the first year of the Medicare physician fee schedule. In fact, the contrary is true. In 1992, Medicare beneficiary liability decreased on two fronts. A smaller proportion of dollars was billed on an unassigned basis (i.e., a 17.2 percent decrease), and for the unassigned dollars remaining, the extra billing rate went down.

From 1991 to 1992, the percent of Medicare allowed charges billed on an assignment-related basis increased from 83.6 percent to 86.5 percent. This was a 3.5 percent increase. During that same period, there was also a 7.3 percent increase in the proportion of charges billed by participating physicians and practitioners. During 1992, there was no change in the billing practices of nonparticipating physicians and practitioners in terms of their ratio of unassigned to assigned charges. In both 1991 and 1992, that ratio was 1.2 to 1.0.

Obviously, variations exist among States, specialties, and types of service. The Medicare assignment rate increased in 1992 in every State except Massachusetts. The increases ranged from 20.1 percent in Wyoming to no change in Massachusetts. In both 1991 and 1992, the Massachusetts Medicare assignment rate was near maximum at 99.4 percent. There appeared to be little or no relationship between assignment rate changes in the various States and changes in their Medicare physician payment amounts. States that were the biggest payment losers under the fee schedule (i.e., Alaska, Florida, Hawaii, and Nevada) all had increases in their Medicare assignment rates in 1992.

In 1992, the percent of allowed charges billed by participants increased in every State except Maryland and Massachusetts. Some States (i.e., North Dakota, Wyoming, Delaware, Kansas, and Hawaii) experienced fairly large increases in the ratio between unassigned and assigned charges billed by their nonparticipating physicians. There was no clear link between these increases and Medicare payment changes, however, since some of the States with increases were modest payment "losers," one a relatively big loser, and another a payment "winner."

During 1992, assignment rates increased for every major physician/practitioner specialty and for every type of service category analyzed. Anesthesiologists--as a specialty--and anesthesia--as a type of service--had the highest assignment rate increases. Other specialties with relatively high increases were family practice, general practice, urology, orthopedic surgery, otolaryngology, and oral surgery. Some of these were payment winners under the fee schedule and some payment losers. For all specialties (except portable x-ray suppliers) and for all types

of service, there was an increase, in 1992, in the proportion of charges billed by participants.

Extra billing is the amount by which submitted charges, on unassigned claims, exceed allowed charges, on unassigned claims. The ratio of the extra billing amount to the allowed charge amount is the extra billing rate. During 1992, extra billing dropped to 22.8 percent. This was a 23.5 percent reduction from the 1991 rate. That extra billing reduction was reflected in every State except Rhode Island; in every physician specialty except radiologists; and for all types of service except invasive imaging procedures. Among States, specialties, and types of service, there was no clear pattern of payment winners reflecting the largest decreases in extra billing and payment losers, the smallest decreases. Data in this section of the report and in other systems recently established by the Health Care Financing Administration (HCFA) indicate that violations of Federal charge limits applicable to the unassigned claims of nonparticipating physicians continue. During 1992, we strengthened our process for monitoring compliance with the limiting charge. All unassigned claims from nonparticipating physicians are currently being reviewed for compliance with the limiting charge. This was put into effect in all carriers early in December 1992. Subject to a nominal tolerance of $1.00, any apparent overcharges result in a letter to the individual physician requiring refunds or reduction of charges.

After a year under the fee schedule and after recently-announced revisions to that fee schedule, physicians and practitioners were given the opportunity to decide whether to participate in the Medicare program for the year beginning January 1, 1993. After this last enrollment opportunity, the participation rate increased by 14.6. The participation enrollment rate in 1993 stands at 59.8 percent. Effective 1993, participation enrollment increased in every State and in every specialty, except multispecialty clinics which is likely an artifact of coding changes allowed in 1992. There were 36 States which had increases of over 10 percent and the highest among those was a 130.8 percent increase in Montana. Anesthesiologists had, by far, the largest 1993 increase in their participation enrollment.

In summary, we have found no significant decreases in assignment rates or proportions of charges billed by participating physicians. Nor have we found significant increases in extra billing rates. Therefore, no plan to address such increases or decreases is being submitted with this report.

BACKGROUND

The first year during which payments were made to physicians under the Medicare physician fee schedule was 1992. That fee schedule replaced the "reasonable charge" payment system that had been in effect since enactment of Medicare in 1965. Generally, physician fee schedule payments are based on the relative resources associated with performing physicians' services and were implemented as a means of bringing more uniformity and equity to Medicare physician payments.

The statute that established the Medicare physician fee schedule (i.e., the Omnibus Budget Reconciliation Act of 1989--OBRA 89) established requirements that the Secretary of Health and Human Services monitor for certain changes that may be occurring under the new payment system. One major aspect of that monitoring responsibility relates to changes in beneficiary liability. Pertinent measures of such liability are rates of physician (1) participation, (2) assignment, and (3) extra billing. Participation rates measure the extent to which physicians sign annual "participation" agreements which require that they accept assignment on all Medicare claims. Another measure of participation is the proportion of Medicare allowed charges billed by participating physicians. Assignment rates indicate the extent to which physicians are accepting Medicare's allowance amount as payment in full for services. (On an assigned claim, Medicare beneficiaries are responsible only for any unmet deductible, the deductible is $100 per year, and for coinsurance of 20 percent of the Medicare allowed charge. As indicated above, participating physicians always accept assignment. However, physicians who have not signed participation agreements can choose to accept or not to accept assignment on a case-by-case basis.) Extra billing rates measure the amounts, on unassigned claims, that beneficiaries potentially pay to physicians above the Medicare allowance amount.

Specifically, section 1848(g)(6) of the Social Security Act, as added by OBRA 89, requires the Secretary to monitor:

- the actual charges of nonparticipating physicians for services furnished beginning January 1, 1991; and
- changes (by specialty, type of service and geographic area) in
    - -- the proportion of expenditures for services provided by participating physicians,
    - -- the proportion of expenditures for services provided on an assignment-related basis, and
    - -- the amounts charged above Medicare fee schedule amounts.

The Secretary is to perform this monitoring on an ongoing basis and report her conclusions in an annual report to Congress. The statute also requires that when the Secretary identifies significant decreases in participation or assignment rates, or identifies increases in extra billing, she is to include in her report recommendations to "address" such trends.

This 1993 annual report presents our findings after measuring for change against the baseline participation, assignment, and extra billing data presented in our first (i.e., our 1992) annual report. Last year's baseline data were for services paid for under the Medicare physician fee schedule and this year's analysis is reviewing only those services as well. Services paid for under the Medicare physician fee schedule include physicians' professional services, services and supplies (other than drugs) which are incident to physicians' services, outpatient physical and occupational therapy, diagnostic x-ray and other diagnostic tests, and x-ray, radium and radioactive isotope therapy. These services are paid for under the Medicare physician fee schedule, regardless of whether they are billed by a physician or nonphysician.

The baseline data presented in last year's Report to Congress was for calendar year 1991. These data were developed by extracting 100 percent data from the 1991 National Claims History. These data included services incurred and processed from January through December 1991. Comparable data for 1992 are being used for comparison purposes in this report. The calendar year 1992 data are for services incurred and processed from January through December 1992 and its source is a 100 percent data extraction from the 1992 National Claims History.

CHANGES IN ASSIGNMENT/PARTICIPATION RATES DURING 1992

In this section of the report we examine the extent to which there were changes, during 1992, in the percent of Medicare allowed charges paid for on an assignment-related basis. Also, we examine changes in the proportion of those assigned charges billed by participating physicians.

Overall

As reported in our 1992 annual report, Medicare assignment rates have generally been increasing over the past decade. By 1991, the percent of allowed charges billed on an assignment-related basis reached 83.6 percent. This pattern continued in 1992, when the figure rose to 86.5 percent--an assignment rate increase, from 1991 to 1992, of 3.5 percent. See Table 1.

Since 1985, the percentage of assigned charges attributable to participating physicians has increased substantially. That percentage increased from 36 percent in fiscal year 1985 to 69.9 percent in calendar year 1991. This was due, in large part, to increases in the percentage of physicians signing on as Medicare participants. In 1992, this pattern continued. In that year, the percentage of assigned allowed charges billed by participating physicians and practitioners equalled 75.0 percent. This was a 7.3 percent increase over the 1991 level. That increase in allowed charges by participants came from what had been both assigned and unassigned billings by nonparticipants. From 1991 to 1992, assigned billings by nonparticipants decreased by 16.1 percent and unassigned billings by nonparticipants decreased by 17.2 percent. See Table 2.

In 1991, nonparticipating physicians billed slightly more unassigned allowed charges than assigned allowed charges and that pattern continued in 1992. The unassigned to assigned ratio of nonparticipants was 1.2 to 1.0 in both 1991 and 1992. See Table 3.

State Analysis

The national pattern of assignment rate increases in 1992 is mirrored in all but one State. In 1992, the highest increases were in Idaho (11.1 percent), Montana (11.0 percent), North Dakota (13.0 percent), Washington (10.5 percent), and Wyoming (20.1 percent). Of note with regard to these States is that they are among the lowest in terms of assignment rates. Most States have 1992 assignment rates at 70 percent or above. However, these five States (plus South Dakota, Oregon, and Minnesota) have 1992 assignment rates of: 37.3 percent (Idaho), 58.1 percent (Montana), 63.2 percent (North Dakota), 68.3 percent (Washington), and 54.0 percent (Wyoming). Therefore, the largest

TABLE 1

Assigned and Unassigned Allowed Charges as Percent of Total Allowed Charges, By State

STATE	Assigned [1]			Unassigned		
	Percent of Total Allowed Charges		Percent Change	Percent of Total Allowed Charges		Percent Change
	1991	1992	1991-1992	1991	1992	1991-1992
Alabama	93.7 %	95.2 %	1.6 %	6.3 %	4.9 %	-23.5 %
Alaska	85.0	88.9	4.6	15.0	11.1	-25.8
Arizona	78.3	81.2	3.7	21.7	18.8	-13.2
Arkansas	92.4	93.4	1.1	7.6	6.6	-13.2
California	85.6	87.4	2.1	14.4	12.6	-12.4
Colorado	70.6	75.3	6.7	29.4	24.7	-16.0
Connecticut	85.6	89.2	4.3	14.5	10.8	-25.5
Delaware	90.6	92.9	2.5	9.4	7.2	-24.0
District of Columbia	86.3	88.6	2.7	13.7	11.4	-16.9
Florida	85.6	89.0	4.0	14.4	11.0	-23.7
Georgia	84.5	87.7	3.8	15.5	12.3	-20.6
Hawaii	85.1	91.4	7.4	14.9	8.6	-42.2
Idaho	33.5	37.3	11.1	66.5	62.7	-5.6
Illinois	75.7	79.0	4.3	24.3	21.0	-13.4
Indiana	78.0	84.5	8.4	22.0	15.5	-29.7
Iowa	68.0	72.6	6.7	32.0	27.4	-14.3
Kansas	91.1	92.7	1.7	8.9	7.3	-17.5
Kentucky	86.7	89.7	3.4	13.3	10.3	-22.2
Louisiana	89.4	91.7	2.6	10.6	8.3	-22.2
Maine	93.1	95.4	2.5	6.9	4.6	-33.7
Maryland	92.1	93.2	1.2	7.9	6.8	-14.5
Massachusetts	99.4	99.4	0.0	0.6	0.6	0.0
Michigan	94.0	95.0	1.1	6.0	5.0	-16.6
Minnesota	43.2	46.4	7.5	56.8	53.8	-5.7
Mississippi	88.1	90.9	3.2	11.9	9.1	-23.9
Missouri	76.0	81.3	6.9	24.0	18.7	-21.8
Montana	52.3	58.1	11.0	47.7	41.9	-12.1
Nebraska	66.1	70.5	6.6	33.9	29.5	-13.0
Nevada	97.2	98.2	1.0	2.8	1.6	-35.7
New Hampshire	77.8	85.4	9.7	22.2	14.7	-33.9
New Jersey	72.8	75.7	4.0	27.2	24.3	-10.7
New Mexico	81.1	83.9	3.5	18.9	16.1	-15.0
New York	81.7	84.3	3.1	18.3	15.7	-14.0
North Carolina	80.5	87.0	8.0	19.5	13.0	-33.2
North Dakota	55.9	63.2	13.0	44.1	36.8	-16.5
Ohio	86.4	90.6	4.9	13.6	9.4	-31.1
Oklahoma	69.4	73.5	5.9	30.6	26.5	-13.4
Oregon	60.6	65.4	8.0	39.4	34.6	-12.3
Pennsylvania	98.3	98.8	0.6	1.7	1.2	-29.4
Rhode Island	99.4	99.5	0.2	0.6	0.5	-16.7
South Carolina	85.4	88.1	3.2	14.6	11.9	-18.9
South Dakota	33.3	35.1	5.2	66.7	64.9	-2.8
Tennessee	88.3	92.4	4.6	11.7	7.8	-35.2
Texas	80.9	84.2	4.1	19.1	15.8	-17.5
Utah	82.1	85.4	4.0	17.9	14.7	-18.2
Vermont	94.8	96.9	2.2	5.2	3.1	-39.7
Virginia	86.6	89.5	3.3	13.4	10.5	-21.3
Washington	61.8	68.3	10.5	38.2	31.7	-17.0
West Virginia	94.5	96.2	1.8	5.5	3.8	-30.8
Wisconsin	67.9	73.8	8.6	32.1	26.2	-18.3
Wyoming	45.0	54.0	20.1	55.0	46.0	-16.4
Puerto Rico/Virgin Is.	98.6	98.8	0.2	1.4	1.2	-14.3
Total [2]	83.6	86.5	3.5	16.3	13.5	-17.2

[1] Based on allowed charges of participating and nonparticipating physicians/practitioners.

[2] Includes allowed charge data for physicians' services for Railroad Retirement Board claims.

Based on summary data from the 1992 National Claims History for physicians' services incurred and processed from January through December 1992.

SOURCE: Bureau of Data Management and Strategy

TABLE 2

Percent of Assigned Allowed Charges for Participating Versus Nonparticipating Physicians and Percent of Unassigned Allowed Charges, By State

State	Participating Physicians/Practitioners			Nonparticipating Physicians/Practitioners					
	Percent of Total Allowed Charges		Percent Change	Assigned		Percent Change	Unassigned		Percent Change
	1991	1992	1991-1992	1991	1992	1991 - 1992	1991	1992	1991 - 1992
Alabama	66.6 %	69.6 %	3.7 %	7.1 %	5.4 %	-24.2 %	6.3 %	4.9 %	-23.6 %
Alaska	61.2	67.3	9.9	23.8	21.6	-9.2	15.0	11.1	-25.8
Arizona	68.7	73.3	6.6	9.6	7.9	-17.8	21.7	18.8	-13.2
Arkansas	84.5	87.2	3.2	7.9	6.2	-21.5	7.6	6.6	-13.2
California	72.6	75.1	3.4	13.0	12.3	-5.2	14.4	12.6	-12.4
Colorado	49.4	56.6	14.6	21.2	16.7	-11.6	29.4	24.7	-16.0
Connecticut	71.2	77.6	9.0	14.3	11.6	-16.6	14.5	10.6	-25.5
Delaware	77.0	84.5	9.7	13.6	6.4	-38.5	9.4	7.2	-24.0
District of Columbia	78.2	82.1	4.9	6.1	6.6	-16.7	13.7	11.4	-16.9
Florida	70.9	77.5	9.3	14.7	11.5	-21.7	14.4	11.0	-23.7
Georgia	70.7	76.8	8.6	13.6	10.8	-21.7	15.5	12.3	-20.6
Hawaii	66.6	83.8	21.9	16.5	7.7	-53.1	14.9	8.6	-42.2
Idaho	19.9	21.6	9.5	13.8	15.4	13.5	66.5	62.7	-5.6
Illinois	61.8	66.7	7.9	13.9	12.2	-11.6	24.3	21.0	-13.4
Indiana	66.2	76.7	15.8	11.6	7.9	-33.3	22.0	15.5	-29.7
Iowa	57.4	64.2	12.0	10.7	8.3	-21.7	32.0	27.4	-14.3
Kansas	66.7	69.6	3.6	4.5	2.9	-35.0	8.9	7.3	-17.5
Kentucky	74.9	80.2	7.2	11.9	9.4	-20.6	13.3	10.3	-22.2
Louisiana	78.7	83.3	5.8	10.7	8.5	-20.6	10.6	8.3	-22.2
Maine	82.0	84.5	3.1	11.1	10.9	-1.8	8.9	4.6	-33.7
Maryland	83.7	81.0	-3.2	8.4	12.2	45.6	7.9	6.8	-14.5
Massachusetts	93.7	92.6	-1.2	5.7	8.9	21.5	0.6	0.6	-6.6
Michigan	88.2	90.4	2.5	5.7	4.5	-21.1	6.0	5.0	-16.6
Minnesota	25.3	30.1	19.3	17.9	16.3	-9.1	56.6	53.6	-5.7
Mississippi	73.8	80.3	8.7	14.3	10.7	-25.1	11.9	9.1	-23.9
Missouri	80.1	83.1	5.0	18.0	18.2	13.7	24.0	18.7	-21.8
Montana	33.5	39.8	18.7	16.6	16.3	-2.7	47.7	41.9	-12.1
Nebraska	57.3	63.2	10.1	8.6	7.4	-16.2	33.9	29.5	-13.0
Nevada	92.0	94.8	2.8	5.2	3.6	-31.8	2.6	1.8	-33.6
New Hampshire	80.8	72.8	19.4	17.0	12.7	-25.2	22.2	14.7	-33.9
New Jersey	50.4	57.2	13.4	22.3	18.5	-17.3	27.2	24.3	-10.7
New Mexico	63.5	68.5	7.9	17.8	15.5	-12.3	16.9	16.1	-15.0
New York	80.7	86.7	9.9	21.1	17.8	-16.3	16.3	15.7	-14.0
North Carolina	65.4	76.6	17.5	15.2	10.2	-32.7	19.5	13.0	-33.2
North Dakota	30.7	53.7	74.8	25.2	9.6	-62.1	44.1	36.8	-16.5
Ohio	76.1	82.6	8.5	10.3	8.0	-21.9	13.6	9.4	-31.1
Oklahoma	52.5	56.2	10.8	16.9	15.3	-9.2	30.6	26.5	-13.4
Oregon	43.7	50.1	14.6	16.9	15.4	-8.9	39.4	34.6	-12.3
Pennsylvania	93.9	95.6	2.1	4.4	3.0	-32.0	1.7	1.2	-33.9
Rhode Island	97.1	98.0	0.9	2.3	1.8	-31.9	0.6	0.5	-26.2
South Carolina	68.0	75.1	10.4	17.4	13.1	-24.7	14.6	11.9	-16.9
South Dakota	19.7	21.6	9.7	13.7	13.5	-1.2	66.7	64.9	-2.6
Tennessee	78.3	85.0	11.4	12.0	7.4	-38.4	11.7	7.6	-35.2
Texas	61.5	70.1	14.1	19.4	14.1	-27.2	19.1	15.8	-17.5
Utah	73.5	78.7	7.1	8.6	6.6	-22.7	17.9	14.7	-16.2
Vermont	87.6	90.7	3.3	7.0	6.2	-11.7	5.2	3.1	-39.7
Virginia	75.4	79.5	5.3	11.2	10.0	-10.5	13.4	10.5	-21.3
Washington	44.0	54.1	22.9	17.6	14.2	-20.2	38.2	31.7	-17.0
West Virginia	84.6	88.6	4.7	10.0	7.6	-23.2	5.5	3.8	-30.6
Wisconsin	48.8	56.4	15.4	19.1	17.4	-8.8	32.1	26.2	-18.3
Wyoming	21.5	39.6	65.3	23.5	14.3	-39.4	55.0	46.0	-16.4
Puerto Rico/ Virgin Islands	91.3	92.4	1.8	7.2	6.5	-9.7	1.4	1.2	-14.3
Total [1]	69.9	75.0	7.3	13.7	11.5	-16.1	16.3	13.5	-17.2

[1] Includes allowed charge data for physicians' services for Railroad Retirement Board claims

Based on summary data from the 1992 National Claims History for physicians' services incurred and processed from January through December 1992

SOURCE: Bureau of Data Management and Strategy

TABLE 3

Nonparticipating Physicians –Ratio of Unassigned Allowed Charges to Assigned Allowed Charges, By State

State	Ratio of Unassigned Allowed Charges to Assigned Allowed Charges		Percent Change 1991 - 1992
	1991	1992	
Alabama	0.9	0.9	0.0 %
Alaska	0.6	0.5	-16.7
Arizona	2.3	2.4	4.3
Arkansas	1.0	1.1	10.0
California	1.1	1.0	-9.1
Colorado	1.4	1.3	-7.1
Connecticut	1.0	0.9	-10.0
Delaware	0.7	0.9	28.6
District of Columbia	1.7	1.7	0.0
Florida	1.0	1.0	0.0
Georgia	1.1	1.1	0.0
Hawaii	0.9	1.1	22.2
Idaho	4.9	4.1	-16.3
Illinois	1.7	1.7	0.0
Indiana	1.9	2.0	5.3
Iowa	3.0	3.3	10.0
Kansas	2.0	2.5	25.0
Kentucky	1.1	1.1	0.0
Louisiana	1.0	1.0	0.0
Maine	0.6	0.4	-33.3
Maryland	0.9	0.6	-33.3
Massachusetts	0.1	0.1	0.0
Michigan	1.1	1.1	0.0
Minnesota	3.2	3.3	3.1
Mississippi	0.8	0.8	0.0
Missouri	1.5	1.0	-33.3
Montana	2.5	2.3	-8.0
Nebraska	3.8	4.0	5.3
Nevada	0.5	0.5	0.0
New Hampshire	1.3	1.1	-15.4
New Jersey	1.2	1.3	8.3
New Mexico	1.1	1.0	-9.1
New York	0.9	0.9	0.0
North Carolina	1.3	1.3	0.0
North Dakota	1.7	3.8	123.5
Ohio	1.3	1.2	-7.7
Oklahoma	1.8	1.7	-5.6
Oregon	2.3	2.2	-4.3
Pennsylvania	0.4	0.4	0.0
Rhode Island	0.3	0.3	0.0
South Carolina	0.8	0.9	12.5
South Dakota	4.9	4.8	-2.0
Tennessee	1.0	1.0	0.0
Texas	1.0	1.1	10.0
Utah	2.1	2.2	4.8
Vermont	0.7	0.5	-28.6
Virginia	1.2	1.0	-16.7
Washington	2.1	2.2	4.8
West Virginia	0.5	0.5	0.0
Wisconsin	1.7	1.5	-11.8
Wyoming	2.3	3.2	39.1
Puerto Rico/Virgin Islands	0.2	0.2	0.0
Total [1]	1.2	1.2	0.0

[1] Includes allowed charge data for physicians' services for Railroad Retirement Board Claims.

Based on summary data from the 1992 National Claims History for physicians' services incurred and processed from January through December 1992.

SOURCE: Bureau of Data Management and Strategy

increases are occurring in States where the assignment rates are lowest.

The only State not experiencing a 1992 assignment rate increase was Massachusetts. That State, which has a law requiring acceptance of Medicare allowed amounts as payment in full as a condition of licensure, had a 99.4 percent assignment rate in both 1991 and 1992. Similarly, the States of Pennsylvania and Rhode Island, both of which also have Medicare mandatory assignment laws, experienced only slight increases in assignment rates from 1991 to 1992. Their 1991 and 1992 assignment rates, like those of Massachusetts, are well over 98 percent.[1] In 1992, Rhode Island had the highest assignment rate (99.5 percent), with high rates also appearing in Massachusetts (99.4 percent), Alabama (95.2 percent), Maine (95.4 percent), Michigan (95.0 percent), Nevada (98.2 percent), Pennsylvania (98.8), Puerto Rico (98.9 percent), Vermont (96.9 percent), and West Virginia (96.2 percent). As a region, the Northeast topped others in terms of Medicare assignment rates. South Dakota had the lowest 1992 assignment rate (35.1 percent); and other low rate States included Idaho (37.3 percent) and Minnesota (46.4 percent). Regionally, the western and midwestern States tended to have the lowest assignment rates. These highs in the northeast and lows in the west parallel the 1991 regional findings regarding assignment rates.

Under the first year of the physician fee schedule (i.e., in 1992), the States of Alaska, Florida, Hawaii, and Nevada experienced the largest decreases per service in Medicare

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[1]Pennsylvania, Rhode Island, and Massachusetts have what are essentially State mandatory assignment provisions that prohibit physicians from billing more than the Medicare allowed charge to Medicare beneficiaries. There are no means or income tests associated with this protection. Connecticut prohibits billing beneficiaries for amounts above the allowed amounts, if the beneficiaries have incomes at a certain level. Vermont prohibits billing beyond the allowed charge amount unless: (1) the beneficiary's income is above a certain level, (2) the beneficiary refuses to sign a statement regarding his or her income level, or (3) the services are office or home visits. In New York State, during 1991 and 1992, a physician's charge to a Medicare beneficiary could not exceed 115 percent of the Medicare allowed charge. Beginning in 1993, that percentage was reduced to 110 percent. Like Vermont's, the New York limit does not apply to home or office visits. Ohio and Florida statutes, which were not enacted until December 1992, also provide Medicare beneficiaries with State balanced billing protection. Thus, we are aware of eight State extra billing laws.

physician payment amounts.[2] It is significant to note that, in 1992, none of these States experienced decreases in their overall physician assignment rates. Also, like most other States, these States had decreases in the proportion of assigned services billed by their nonparticipating physicians, and increases in the proportion of services billed by participants. In short, there generally appears to be little or no relationship between assignment rate changes in the various States and changes in their Medicare physician payment amounts.

The 1992 increase in the national percentage of allowed charges billed by participants was reflected in each State except Maryland and Massachusetts. In those States, there were slight decreases in the proportion of charges billed by participants. The largest 1992 increases in that proportion were in Hawaii, North Dakota, Washington, and Wyoming. See Table 2. Of note in these States is the fact that there appears to be no consistent relationship between these changes in the proportion of allowed charges billed by participants and the 1991 to 1992 changes in physician/practitioner participation enrollment rates. Maryland experienced one of the highest 1992 increases in its physician/practitioner participation enrollment rate (i.e., in the proportion of physicians/practitioners signing participation agreements) at 29.6 percent, but had a lower percentage of allowed charges attributable to participants. North Dakota had relatively low increases in its 1992 participation enrollment rate, but very high increases in its percentage of allowed charges billed by participants. Hawaii, Washington, and Wyoming reflected significant 1992 increases in both measures. And finally, Massachusetts had modest decreases in both.

In Maryland and Massachusetts, although there was a reduction in allowed charges billed by participants, there was no overall decrease in the assignment rate of those States. Instead, there were notable increases in the proportion of assigned charges billed by nonparticipating physicians. This is a somewhat surprising result in Massachusetts--a mandatory assignment State, since one would expect that most if not all physicians there would become participants, rather than increase billings on an assignment-related basis as nonparticipants. (See subsequent discussion on participation enrollment rates in mandatory assignment States.) In almost all of the remaining States, i.e., those where there was an increase in the proportion of allowed charges billed by participants, the national pattern was reflected in that the increases came from decreases in both assigned and unassigned allowed charges billed by nonparticipants.

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[2]References in this report to payment amounts and changes under the Medicare physician fee schedule are based on projected payments or changes per service.

In 1992, about two-thirds of the States reflected the national pattern of nonparticipating physicians billing more unassigned than assigned allowed charges. We also found that there tended to be a relationship between this ratio of unassigned to assigned billing and the States where nonparticipants bill for most of the Medicare allowed charges. We found that in every State where nonparticipants billed for more than half of the total allowed Medicare charges, nonparticipants billed some of the highest proportions of unassigned dollars. In Idaho, for example, nonparticipants billed almost 80 percent of the 1992 Medicare allowed charges in that State and, among those allowed charges, the ratio of unassigned to assigned charges was 4.1 to 1. Similar findings can be made with regard to Minnesota, Montana, South Dakota, and Wyoming. See Tables 2 and 3. Note, however, that the reverse is not always true. There are States (for example, Arizona, Iowa, Nebraska, and North Dakota) where nonparticipants bill a very high proportion of unassigned to assigned charges, but where most of the allowed charges in the States are billed by participating physicians.

States where, in 1992, nonparticipants billed substantially more assigned than unassigned charges tended to be States where local statutes required, in some or all circumstances, such assignment-related billing by all physicians--both participating and nonparticipating. See Rhode Island, Massachusetts, Pennsylvania, and Vermont.

The States that had the highest increases, from 1991 to 1992, in the ratio of unassigned to assigned billings by nonparticipants were North Dakota (123.5 percent), Wyoming (39.1 percent), Delaware (28.6 percent), Kansas (25 percent), and Hawaii (22.2 percent).. North Dakota, Delaware, and Kansas were modest losers under the physician fee schedule. Hawaii had a relatively large reduction in its Medicare payments per service and Wyoming was a modest payment winner. Therefore, these larger increases did not uniformly occur in States where there were large payment reductions.

Specialty Analysis

In 1992, there were increases in the Medicare assignment rate for all physician and nonphysician specialties receiving payments under the Medicare physician fee schedule. See Table 4. (See Appendix 1 for a discussion of physician specialty changes and the meaning of those changes for this analysis.) Anesthesiologists had the largest assignment rate increase--15.1 percent, and nephrologists had the smallest physician assignment rate increase--0.3 percent. In both 1991 and 1992, nephrologists had the highest assignment rate from among all of the physician specialties--94.9 percent and 95.2 percent respectively. Therefore, their small rate of increase is predictable and not indicative of adverse financial liability

TABLE 4

Assigned and Unassigned Allowed Charges as Percent of Total Allowed Charges, By Specialty

Specialty	Assigned [1]			Unassigned		
	Percent of Total Allowed Charges		Percent Change 1991-1992	Percent of Total Allowed Charges		Percent Change 1991-1992
	1991	1992		1991	1992	
All Specialties [2]	83.6 %	86.5 %	3.5 %	16.3 %	13.5 %	-17.2 %
Physicians (MDs and DOs)	83.6	86.5	3.5	16.4	13.6	-17.2
Family Practice	75.7	79.7	5.3	24.2	20.3	-16.1
General Practice	81.9	86.2	5.3	18.1	13.8	-23.8
Cardiology	88.1	90.0	2.2	12.0	10.0	-16.7
Dermatology	82.2	83.8	1.9	17.9	16.2	-9.5
Internal Medicine	78.2	81.3	4.0	21.8	18.7	-14.2
Gastroenterology	88.9	89.8	1.0	11.1	10.2	-8.1
Nephrology	94.9	95.2	0.3	5.1	4.8	-5.9
Neurology	84 9	87.3	2.8	15.1	12.7	-15.9
Obstetrics-Gynecology	78.7	81.6	3.7	21.3	18.4	-13.8
Psychiatry	89.1	90.6	1.7	10.9	9.4	-13.8
Pulmonary	88.6	90.2	1.8	11.4	9.8	-14.0
Urology	76.3	80.7	5.8	23.7	19.3	-18.6
Anesthesiology	69.4	79.9	15.1	30.7	20.2	-34.2
Pathology	87.0	91.1	4.7	13.0	8.9	-31.5
Radiology [3]	87.7	90.2	2.9	12.3	9.8	-20.3
General Surgery	86.2	89.3	3.6	13.8	10.8	-21.7
Neurosurgery	82.3	84.6	2.8	17.7	15.3	-13.6
Ophthalmology	88.3	89.6	1.5	11.7	10.4	-11.1
Orthopedic Surgery	79.9	84.1	5.3	20.1	15.9	-20.9
Otolaryngology	77.6	82.1	5.8	22.4	18.0	-19.6
Plastic Surgery	86.4	89.0	3.0	13.5	11.0	-18.5
Thoracic Surgery	88.5	89.8	1.5	11.5	10.1	-12.2
Clinic or Other Group Practice	85.1	88.7	4.2	14.9	11.2	-24.8
All Other Physicians	90.0	90.1	0.1	10.0	9.9	-1.0
Limited License Practitioners (LLPs)	82.9	83.9	1.2	17.1	16.2	-5.5
Optometry	88.7	90.0	1.5	11.3	10.0	-11.5
Chiropractic	53.5	55.2	3.2	46.5	44.8	-3.7
Podiatry	89.6	91.2	1.8	10.4	8.7	-16.3
Oral Surgery	64.6	69.3	7.3	35.4	30.7	-13.3
Total Physicians (MDs, DOs and LLPs)	83.6	86.4	3.3	16.4	13.6	-17.3
Nonphysician Practitioners [4]	75.1	83.8	11.6	24.9	16.2	-34.9
Suppliers	95.8	97.3	1.6	4.2	2.7	-34.9
Portable X-Ray Supplier (Independent)	98.9	99.1	0.2	1.1	0.9	-18.9
Independent Laboratory	94.6	96.1	1.6	5.4	3.9	-27.8
All Other Suppliers	94.2	97.3	3.3	5.8	2.7	-53.4

[1] Based on assigned allowed charges of participating and nonparticipating physicians.
[2] Includes physicians (doctors of medicine (MDs), doctors of osteopathy (DOs), and limited license practitioners) (LLPs)- (optometrists, chiropractors, podiatrists and oral surgeons) Also includes nonphysician practitioners and suppliers.
[3] Includes radiation therapy and nuclear medicine specialties
[4] Includes audiologists, physical therapists, occupational therapists, and psychologists (billing HCPCS 90830). Excludes certified nurse-midwives, certified registered nurse anesthetists nurse practitioners and clinical social workers.

Based on summary data from the 1992 National Claims History for physicians' services incurred and processed from January through December 1992.

SOURCE Bureau of Data Management and Strategy

consequences for beneficiaries using their services. In addition to anesthesiologists, relatively high assignment rate increases were experienced by family practice (5.3 percent), general practice (5.3 percent), urology (5.8 percent), orthopedic surgery (5.3 percent), otolaryngology (5.8 percent), and oral surgery (7.3 percent). These were relatively high increases compared to the national assignment rate increase of 3.5 percent.

Of the seven physician specialties with the highest assignment rate increases, three were payment winners under the physician fee schedule--family practice, general practice, and otolaryngology and three were losers--urology, anesthesiology, and orthopedic surgery. (We have no fee schedule payment projected impact data for oral surgery.) Thus, no payment change/assignment change relationship emerges and this is confirmed when we find that other specialties that were big payment winners (i.e, optometry, chiropractic, and podiatry) had low or very low assignment rate increases. Of course, it is reasonable to also observe that the 1992 assignment rates for optometrists and podiatrists were relatively high, despite the relatively low rates of increase for those specialties.

For all specialties except one (portable x-ray supplier), 1992 saw an increase in the proportion of charges billed by participating physicians. And in all but three of those specialties where these increases occurred, there were parallel decreases in both the assigned and unassigned charges billed by nonparticipants. In the remaining three specialties, when the participant proportions increased, so too did the proportion of assigned charges billed by nonparticipants. Those three remaining specialties were oral surgery, portable x-ray suppliers, and independent laboratories. See Table 5.

The physician specialties with the largest increases in the proportion of charges billed by participants were family practice, urology, anesthesiology, and otolaryngology.

When we examine the 1992 billing patterns of nonparticipants, by specialty, we find that most specialties are clustered around the 1.2 to 1.0 national ratio of unassigned to assigned billings. Some are slightly below and some are slightly above. Chiropractors are the outlier specialty on the high side--with an unassigned to assigned ratio of 3.7 to 1.0. Nonparticipating psychiatrists and nephrologists, who billed twice as many assigned as unassigned dollars, are the physician outliers on the low side. See Table 6.

Nonparticipating gastroenterologists and ophthalmologists had the highest increases, from 1991 to 1992, in their unassigned to assigned billing ratio. Both specialties did experience substantial per payment reductions under the first year of the fee schedule.

TABLE 5

Percent of Assigned Allowed Charges for Participating Versus Nonparticipating Physicians and Percent of Unassigned Allowed Charges, By Specialty

Specialty	Participating Physicians/practitioners			Nonparticipating Physicians/practitioners					
	Percent of Total Allowed Charges		Percent Change 1991-1992	Assigned		Percent Change 1991-1992	Unassigned		Percent Change 1991-1992
				Percent of Total Allowed Charges			Percent of Total Allowed Charges		
	1991	1992		1991	1992		1991	1992	
All Specialties [1]	86.6 %	75.0 %	7.3 %	13.7 %	11.5 %	-16.1 %	16.3 %	13.5 %	-17.2 %
Physicians (MDs and DOs)	70.1	75.3	7.5	13.5	11.2	-17.1	16.4	13.6	-17.2
Family Practice	80.7	85.7	16.1	16.0	14.0	-12.5	24.2	20.3	-16.1
General Practice	67.7	73.5	8.6	14.2	12.7	-10.6	18.1	13.8	-23.8
Cardiology	75.6	80.3	5.6	12.3	9.7	-21.1	12.0	10.0	-16.7
Dermatology	71.5	74.9	4.8	10.7	8.9	-16.8	17.6	16.2	-8.5
Internal Medicine	61.6	67.0	6.4	16.4	14.3	-12.6	21.6	16.7	-14.2
Gastroenterology	76.4	79.8	4.5	12.5	10.0	-20.0	11.1	10.2	-8.1
Nephrology	84.3	86.0	2.0	10.6	9.2	-13.2	5.1	4.8	-5.9
Neurology	66.6	71.6	8.0	18.3	15.4	-15.8	15.1	12.7	-15.9
Obstetrics-Gynecology	63.2	67.8	7.3	15.5	13.8	-10.6	21.3	18.4	-13.6
Psychiatry	66.9	70.6	5.6	22.2	19.6	-10.6	10.9	9.4	-13.6
Pulmonary	74.3	76.0	5.0	14.3	12.2	-14.7	11.4	6.6	-14.0
Urology	61.4	66.3	12.6	14.6	11.4	-23.5	23.7	16.3	-16.6
Anesthesiology	50.3	65.6	30.6	19.1	14.1	-26.2	30.7	20.2	-34.2
Pathology	77.6	82.6	8.7	6.4	6.3	-11.7	13.0	6.6	-31.9
Radiology [2]	76.2	82.6	4.7	8.5	7.3	-14.1	12.3	6.6	-26.3
General Surgery	73.6	76.4	7.4	12.3	9.6	-19.5	13.6	10.6	-21.7
Neurosurgery	66.0	72.6	7.1	14.3	11.6	-17.5	17.7	15.3	-13.6
Ophthalmology	76.4	80.7	5.6	11.6	8.9	-25.2	11.7	10.4	-11.1
Orthopedic Surgery	67.2	73.4	6.2	12.7	10.7	-16.7	20.1	15.6	-20.6
Otolaryngology	62.6	66.6	11.2	15.0	12.5	-16.7	22.4	16.0	-19.6
Plastic Surgery	69.4	75.6	9.2	17.0	13.2	-22.4	13.5	11.0	-18.5
Thoracic Surgery	76.6	81.2	3.3	8.6	6.9	-13.1	11.5	10.1	-12.2
Clinic or Other Group Practice	73.2	78.6	7.5	11.9	9.6	-17.6	14.9	11.2	-24.6
All Other Physicians	73.0	77.6	9.7	17.0	12.2	-28.2	10.0	9.9	-1.0
Limited License Practitioners (LLPs)	70.2	72.7	3.5	12.6	11.2	-11.4	17.1	16.2	-5.5
Optometry	76.5	81.7	2.0	9.2	8.3	-9.8	11.3	10.0	-11.5
Chiropractic	40.6	43.2	8.4	12.9	12.0	-7.0	48.5	44.6	-8.7
Podiatry	76.5	78.9	4.4	13.1	11.3	-13.7	10.4	8.7	-16.3
Oral Surgery	42.4	46.3	9.2	22.2	23.0	3.6	35.4	30.7	-13.3
Total Physicians (MDs, DOs and LLPs)	70.1	75.2	7.3	13.5	11.2	-16.9	16.4	13.6	-17.3
Nonphysician Practitioners [3]	36.1	46.3	28.8	37.0	35.5	-4.1	24.9	18.2	-34.9
Suppliers	67.5	72.0	9.6	28.3	25.3	-10.7	4.2	2.7	-34.9
Portable X-Ray Supplier (Independent)	75.9	75.5	-0.1	23.3	23.6	1.3	1.1	0.9	-16.9
Independent Laboratory	69.0	71.0	2.0	25.0	28.1	0.3	5.4	3.9	-27.8
All Other Suppliers	51.7	70.6	36.6	42.5	26.7	-37.2	5.8	2.7	-53.4

[1] Includes physicians (doctors of medicine (MDs), doctors of osteopathy (DOs), and limited license practitioners) (LLPs) - (optometrists, chiropractors, podiatrists and oral surgeons). Also includes nonphysician practitioners and suppliers.
[2] Includes radiation therapy and nuclear medicine specialties.
[3] Includes audiologists, physical therapists, occupational therapists, and psychologists (billing HCPCS 90330).
Excludes certified nurse-midwives, certified registered nurse anesthetists, nurse practitioners and clinical social workers.

Based on summary data from the 1992 National Claims History for physicians' services incurred and processed from January through December 1992.

SOURCE: Bureau of Data Management and Strategy

TABLE 6

Nonparticipating Physicians --Ratio of Unassigned Allowed Charges to Assigned Allowed Charges,
By Specialty

Specialty	Ratio of Unassigned Allowed Charges to Assigned Allowed Charges		Percent Change 1991 - 1992
	1991	1992	
All Specialties [1]	1.2	1.2	**0.0 %**
Physicians (MDs and DOs)	1.2	1.2	**0.0**
Family Practice	1.5	1.5	**0.0**
General Practice	1.3	1.1	**-15.4**
Cardiology	1.0	1.0	**0.0**
Dermatology	1.7	1.8	**5.9**
Internal Medicine	1.3	1.3	**0.0**
Gastroenterology	0.9	1.0	**11.1**
Nephrology	0.5	0.5	**0.0**
Neurology	0.8	0.8	**0.0**
Obstetrics-Gynecology	1.4	1.3	**-7.1**
Psychiatry	0.5	0.5	**0.0**
Pulmonary	0.8	0.8	**0.0**
Urology	1.6	1.7	**6.2**
Anesthesiology	1.6	1.4	**-12.5**
Pathology	1.4	1.1	**-21.4**
Radiology [2]	1.4	1.3	**-7.1**
General Surgery	1.1	1.1	**0.0**
Neurosurgery	1.2	1.3	**8.3**
Ophthalmology	1.0	1.2	**20.0**
Orthopedic Surgery	1.6	1.5	**-6.3**
Otolaryngology	1.5	1.4	**-6.7**
Plastic Surgery	0.8	0.8	**0.0**
Thoracic Surgery	1.2	1.2	**0.0**
Clinic or Other Group Practice	1.3	1.1	**-15.4**
All Other Physicians	0.6	0.8	**33.3**
Limited License Practitioners (LLPs)	1.4	1.4	**0.0**
Optometry	1.2	1.2	**0.0**
Chiropractic	3.6	3.7	**2.8**
Podiatry	0.8	0.8	**0.0**
Oral Surgery	1.6	1.3	**-18.8**
Total Physicians (MDs, DOs and LLPs)	1.2	1.2	**0.0**
Nonphysician Practitioners [3]	0.7	0.5	**-28.6**
Suppliers	0.1	0.1	**0.0**
Portable X-Ray Supplier (Independent)	0.0	0.0	**0.0**
Independent Laboratory	0.2	0.2	**0.0**
All Other Suppliers	0.1	0.1	**0.0**

[1] Includes physicians (doctors of medicine (MDs), doctors of osteopathy (DOs), and limited license practitioners (LLPs) (optometrists, chiropractors, podiatrists and oral surgeons). Also includes nonphysician pratitioners and suppliers.

[2] Includes radiation therapy and nuclear medicine specialties.

[3] Includes audiologists, physical therapists, occupational therapists, and psychologists (billing HCPCS 90830). Excludes certified nurse-midwives, certified registered nurse anesthetists, nurse practitioners and clinical social workers.

Based on summary data from the 1992 National Claims History for physicians' services incurred and processed from January through December 1992.

SOURCE: Bureau of Data Management and Strategy

Type of Service Analysis

See Appendix 2 for a listing of the services included in the various type of service categories discussed in this section.

For every major type of service paid for under the Medicare physician fee schedule, 1992 brought an increase in the proportion of services paid for on an assignment-related basis. See Table 7. The largest increase was for anesthesia services and the smallest for dialysis care. Anesthesia went from an assignment rate of 70.0 percent in 1991 to 80.2 percent in 1992--an increase of almost 15 percent. Assignment for dialysis services, on the other hand, increased by only 0.6 percent--a reasonable result since assignment for this type of service is and has been near the maximum level for a number of years (i.e., 97.8 percent in 1991 and 98.4 percent in 1992). In addition to anesthesia services, relatively high 1992 increases were also observed for office visits (5.2 percent increase) and major orthopedic procedures (5.3 percent increase).

When we compare these higher assignment rate increases to changes in Medicare payment rates for these services, no pattern or relationship emerges. In 1992, while average payments for office visits increased substantially, those for hip and knee replacements decreased by over 15 percent and anesthesiologists' payments per service decreased by 11 percent. See Table 8 and page 59618 of the November 25, 1991 Federal Register. Thus, for these three types of service, relatively high assignment rate increases were observed for both payment winners and losers.

In 1992, for every type of service category, the proportion of allowed charges billed by participating physicians increased and, within each of those categories, those increases resulted from reductions in both assigned and unassigned services billed by nonparticipating physicians/practitioners. The most dramatic increase in billings by participants occurred in the anesthesia category--29.4 percent. See Table 9. Therefore, in 1992, for anesthesia services, not only was there a large increase in the overall assignment rate, but there was an even larger increase in the proportion of allowed charges billed by participating physicians.

In 1992, the highest ratios of unassigned to assigned billings, by nonparticipating physicians, occurred in office visits (2.4 to 1.0) and chiropractic services (3.7 to 1.0). For office visits, this represented a small decrease from 1991 to 1992. For chiropractic services, this was a modest increase. From 1991 to 1992, the largest increases in the ratio of unassigned to assigned billings by nonparticipants occurred in the procedural or surgical type of service categories. Nonparticipants increased their proportions of unassigned billings for major cardiovascular procedures, eye procedures, minor procedures, and

TABLE 7

Assigned and Unassigned Allowed Charges as Percent of Total Allowed Charges, By Type of Service

Type of Service [2]	Assigned [1]			Unassigned		
	1991 Percent of Total Allowed Charges	1992 Percent of Total Allowed Charges	Percent Change 1991 - 1992	1991 Percent of Total Allowed Charges	1992 Percent of Total Allowed Charges	Percent Change 1991 - 1992
Anesthesia	70.0 %	80.2 %	14.6 %	30.0 %	19.8 %	-34.0 %
Standard Imaging	84.4	87.5	3.7	15.7	12.5	-20.4
Advanced Imaging	88.0	90.3	2.6	12.1	9.6	-20.7
Echography	90.3	92.0	1.9	9.7	7.9	-18.6
Imaging/Procedure	87.7	91.1	3.9	12.3	8.9	-27.6
Office Visits	73.5	77.3	5.2	26.5	22.7	-14.3
Hospital Visits	86.7	89.2	2.9	13.3	10.8	-18.8
Emergency Department Care	96.4	97.7	1.3	3.7	2.3	-37.8
Home/Nursing Home Visits	90.6	92.4	2.0	9.4	7.6	-19.1
Specialist Visits	86.1	88.7	3.0	14.0	11.3	-19.3
Consultations	86.5	88.2	2.0	13.5	11.8	-12.6
Major Procedures General	81.1	84.7	4.4	18.9	15.3	-19.0
Major Cardiovascular Procedures	87.6	90.3	3.1	12.3	9.7	-21.1
Major Orthopedic Procedures	79.9	84.1	5.3	20.1	15.9	-20.9
Eye Procedures - Surgery	90.2	91.2	1.1	9.9	8.9	-10.1
Ambulatory Procedures	83.9	86.7	3.3	16.1	13.3	-17.4
Minor Procedures	84.5	86.6	2.5	15.6	13.5	-13.5
Oncology	87.4	89.9	2.9	12.6	10.1	-19.8
Endoscopy	83.5	86.1	3.1	16.5	13.9	-15.8
Dialysis	97.8	98.4	0.6	2.1	1.6	-23.8
Lab Tests	91.6	94.4	3.1	8.4	5.7	-32.1
Other Tests	85.6	87.6	2.3	14.4	12.5	-13.2
Assistant at Surgery	83.4	86.6	3.8	16.6	13.5	-18.7
Chiropractic	54.0	55.4	2.6	46.1	44.7	-3.0
Total [3]	83.6	86.5	3.5	16.3	13.5	-17.2

[1] Based on allowed charges for assigned services of participating and nonparticipating physicians/practitioners.

[2] All types of service except 'assistant at surgery' are based on procedure code groupings developed by the Urban Institute. See Appendix A for additional type of service definitions. Type of service 'assistant at surgery' based on HCFA type of service code.

[3] Includes data for not otherwise classified CPT and HCFA assigned codes.

Based on summary data from the 1992 National Claims History for physicians' services incurred and processed from January through December 1992.

SOURCE: Bureau of Data Management and Strategy

Table 8

FEE SCHEDULE PAYMENTS VS. 1991 AVERAGE PAYMENTS FOR SELECTED HIGH VOLUME PHYSICIAN SERVICES

PHYSICIAN SERVICE	1991 AVERAGE PAYMENT	1992* TRANSITION PAYMENT	FULL FEE** SCHEDULE	NPRM** FULL FEE SCHEDULE
Office Visit, New, Level 1 of 5	$27	$26	$26	$23
Office Visit, New, Level 2 of 5	34	38	41	36
Office Visit, New, Level 3 of 5	40	47	55	48
Office Visit, New, Level 4 of 5	61	71	80	70
Office Visit, New, Level 5 of 5	67	80	100	88
Office Visit, Established, Level 1 of 5	13	13	13	11
Office Visit, Established, Level 2 of 5	20	22	22	20
Office Visit, Established, Level 3 of 5	26	30	31	27
Office Visit, Established, Level 4 of 5	39	45	47	42
Office Visit, Established, Level 5 of 5	57	66	73	65
Hospital Visit, Initial, Level 1 of 3	49	56	59	52
Hospital Visit, Initial, Level 2 of 3	77	88	94	83
Hospital Visit, Initial, Level 3 of 3	84	99	119	105
Hospital Visit, Subsequent, Level 1 of 3	28	31	31	27
Hospital Visit, Subsequent, Level 2 of 3	34	40	45	39
Hospital Visit, Subsequent, Level 3 of 3	47	55	60	52
Total Hip Joint Replacement (CPT: 27130)	2,105	1,772	1,697	1,513
Total Knee Replacement (CPT: 27447)	2,241	1,886	1,816	1,588
Insertion of Heart Pacemaker (CPT: 33207)	811	694	575	500
Coronary Arteries Bypass (CPT:33512)	3,178	2,726	2,225	1,952
Upper GI Endoscopy, Diagnosis (CPT: 43235)	292	250	207	183
Sigmoidoscopy (CPT: 45330)	100	85	78	71
Diagnostic Colonoscopy (CPT: 45378)	337	286	263	223
Removal of Gallbladder (CPT: 47600)	743	626	599	535
Repair Inguinal Hernia (CPT: 49505)	445	379	335	297
Cystoscopy (CPT: 52000)	112	113	113	92
Prostatectomy (TUR) (CPT: 52601)	981	824	802	714
Total Hysterectomy (CPT: 58150)	834	805	805	603
Lasering, Secondary Cataract (CPT: 66821)	516	448	327	286
Remove Cataract, Insert Lens (CPT: 66984)	1,342	1,151	941	847
X-Ray Exam of Chest (CPT: 71020-PC)	14	12	11	9
Contrast CAT Scans, Abdomen (CPT: 74170-PC)	91	77	69	58
Weekly Radiation Therapy (CPT: 77425-PC)	160	136	121	101
Surg. Path., Gross and Micro. (CPT: 88305-PC)	59	51	43	38

* To determine the 1992 transition payment, the 1991 average payment is updated by 1.9 percent and reduced by 5.5 to reflect adjustment for the transition assymetry.

** Includes an annual update of 1.9 percent for 1992.

Source: Bureau of Policy Development, Office of Payment Policy, HCFA

TABLE 9

Percent of Assigned Allowed Charges for Participating Versus Nonparticipating Physicians and Percent of Unassigned Allowed Charges, By Type of Service

Type of Service [2]	Participating Physicians/Practitioners [1]			Nonparticipating Physicians/Practitioners					
				Assigned Services			Unassigned		
	1991 Percent of Total Allowed Charges	1992 Percent of Total Allowed Charges	Percent Change 1991 - 1992	1991 Percent of Total Allowed Charges	1992 Percent of Total Allowed Charges	Percent Change 1991 - 1992	1991 Percent of Total Allowed Charges	1992 Percent of Total Allowed Charges	Percent Change 1991 - 1992
Anesthesia	51.0 %	66.0 %	29.4 %	19.0 %	14.2 %	-25.3 %	30.0 %	19.8 %	-34.0 %
Standard Imaging	74.1	78.4	5.8	10.3	9.1	-11.7	15.7	12.5	-20.4
Advanced Imaging	77.8	81.4	4.6	10.2	8.9	-12.7	12.1	9.6	-20.7
Echography	77.5	81.4	5.0	12.8	10.6	-17.2	9.7	7.9	-18.6
Imaging/Procedure	77.1	82.8	7.4	10.6	8.3	-21.7	12.3	8.9	-27.6
Office Visits	62.9	67.7	7.6	10.6	9.8	-9.4	26.5	22.7	-14.3
Hospital Visits	67.0	72.4	8.1	19.7	16.8	-14.7	13.3	10.8	-18.8
Emergency Department Care	86.1	89.5	3.9	10.3	8.2	-20.4	3.7	2.3	-37.8
Home/Nursing Home Visits	68.9	73.1	6.1	21.7	19.3	-11.1	9.4	7.6	-19.1
Specialist Visits	73.8	77.6	5.1	12.3	11.1	-9.8	14.0	11.3	-19.3
Consultations	70.6	75.0	6.2	15.9	13.2	-17.0	13.5	11.8	-12.6
Major Procedures General	67.0	73.1	9.1	14.1	11.6	-17.7	18.9	15.3	-19.0
Major Cardiovascular Procedures	75.8	81.3	7.3	11.8	9.0	-23.7	12.3	9.7	-21.1
Major Orthopedic Procedures	66.0	72.5	9.8	13.9	11.6	-16.5	20.1	15.9	-20.9
Eye Procedures - Surgery	76.9	81.3	5.7	13.3	9.9	-25.6	9.9	8.9	-10.1
Ambulatory Procedures	69.9	75.4	7.9	14.0	11.3	-19.3	18.1	13.3	-17.4
Minor Procedures	70.7	75.0	6.1	13.8	11.6	-15.9	15.8	13.5	-13.5
Oncology	76.5	81.0	5.9	10.9	8.9	-18.3	12.8	10.1	-19.8
Endoscopy	69.8	75.4	8.0	13.7	10.7	-21.9	16.5	13.9	-15.8
Dialysis	84.7	88.2	4.1	13.1	10.2	-22.1	2.1	1.8	-23.8
Lab Tests	74.5	79.1	6.2	17.1	15.3	-10.5	8.4	5.7	-32.1
Other Tests	71.4	74.4	4.2	14.2	13.2	-7.0	14.4	12.5	-13.2
Assistant at Surgery	66.4	72.5	9.2	17.0	14.1	-17.1	18.6	13.5	-18.7
Chiropractic	41.1	43.4	5.6	12.9	12.0	-7.0	46.1	44.7	-3.0
Total [3]	69.9	75.0	7.3	13.7	11.5	-16.1	18.3	13.5	-17.2

[1] Includes physicians (doctors of medicine (MDs), doctors of osteopathy (DOs), and limited license practitioners) (LLPs)- (optometrists, chiropractors, podiatrists and oral surgeons) Also includes nonphysician practitioners and suppliers.

[2] All types of service except 'assistant at surgery' are based on procedure code groupings developed by the Urban Institute. See Appendix A for additional type of service definitions. Type of service 'assistant at surgery' based on HCFA type of service code.

[3] Includes data for not otherwise classified CPT codes and HCFA assigned codes.

Based on summary data from the 1992 National Claims History for physicians' services incurred and processed from January through December 1992

SOURCE: Bureau of Data Management and Strategy

endoscopy. However, there were no increases for major general or orthopedic procedures. Nonparticipants also increased their proportion of unassigned billing for consultation services. Procedural or surgical services experienced payment reductions under the physician fee schedule. Consequently, it is possible that the increases in the ratio of unassigned to assigned billing, in some surgical type of service categories, are related to lower Medicare payments in those categories. See Table 10.

TABLE 10

Nonparticipating Physicians -- Ratio of Unassigned Allowed Charges to Assigned Allowed Charges, By Type of Service

Type of Service [1]	Ratio of Unassigned Allowed Charges to Assigned Allowed Charges		Percent Change 1991 - 1992
	1991	1992	
Anesthesia	1.6	1.4	-12.5 %
Standard Imaging	1.5	1.4	-8.7
Advanced Imaging	1.2	1.1	-8.3
Echography	0.8	0.7	-12.5
Imaging/Procedure	1.2	1.1	-8.3
Office Visits	2.5	2.4	-4.0
Hospital Visits	0.7	0.6	-14.3
Emergency Department Care	0.4	0.3	-25.0
Home/Nursing Home Visits	0.4	0.4	0.0
Specialist Visits	1.1	1.0	-9.1
Consultations	0.8	0.9	12.5
Major Procedures General	1.3	1.3	0.0
Major Cardiovascular Procedures	1.0	1.1	10.0
Major Orthopedic Procedures	1.4	1.4	0.0
Eye Procedures - Surgery	0.7	0.9	28.6
Ambulatory Procedures	1.2	1.2	0.0
Minor Procedures	1.1	1.2	9.1
Oncology	1.2	1.1	-8.3
Endoscopy	1.2	1.3	8.3
Dialysis	0.2	0.2	0.0
Lab Tests	0.5	0.4	-20.0
Other Tests	1.0	0.9	-10.0
Assistant at Surgery	1.0	1.0	0.0
Chiropractic	3.6	3.7	2.8
Total [2]	1.2	1.2	0.0

[1] All types of service except 'assistant at surgery' are based on procedure code groupings developed by the Urban Institute. See Appendix A for additional type of service definitions. Type of service 'assistant at surgery' based on HCFA type of service code.

[2] Includes data for not otherwise classified CPT and HCFA assigned codes.

Based on summary data from the 1992 National Claims History for physicians' services incurred and processed from January through December 1992.

Source: Bureau of Data Management and Strategy.

CHANGES IN EXTRA BILLING AMOUNTS DURING 1992

Background

As indicated earlier, to measure extra billing is to measure the extent to which nonparticipating physicians charge Medicare beneficiaries amounts above the Medicare allowed charge amount. This constitutes "potential" extra billing since, in our data system, we can determine only that the beneficiary was charged, not whether the physician actually collected. These extra billing determinations are made for only unassigned claims, since, on assigned claims, a beneficiary's liability is limited to the allowed charge amount, regardless of the amount written on the bill by the provider. We note that in our analyses, this year and last, we make the assumption that there is little if any extra billing on assigned claims and that participating physicians always bill on an assigned basis, consistent with their participation agreements.[3]

As in last year's report, we are defining extra billing as the amount by which submitted charges, on unassigned claims, exceed allowed charges, on unassigned claims. The ratio of the extra billing amount to the allowed charge amount is the extra billing rate. We provide no extra billing per claim data in this report.

During both 1991 and 1992, there were Federal statutory limits, called limiting charges, on the amounts that nonparticipating physicians could charge Medicare beneficiaries on unassigned claims. During 1991, that limit was no more than 125 percent of the Medicare physician fee schedule amount, except that for primary care and evaluation and management services the limit was 140 percent. During 1992, it was no more than 120 percent of the fee schedule amount and, starting in 1993, it is 115 percent of the fee schedule amount. Also, as noted above, certain States have laws with similar limits. It should be noted that since the nonparticipating fee schedule amount is 95 percent of the full or participating physician fee schedule amount, the effective limiting charge amounts were 114 percent of the full fee schedule

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[3]Since February 1993, Medicare claims processing instructions have provided that all claims from participating physicians are to be processed as assigned claims even if the physician has checked the nonassignment block on the claim form (HCFA-1500) or even if the physician has failed to check either the nonassignment or assignment block. In order to avoid this automatic assignment on a given claim, a participating physician must attach a statement to the claim stating "Patient refuses to assign benefits." See Medicare Carriers Manual, Part 3, Claims Processing, section 3040.3.

amount in 1992 and they are 109 percent of that amount in 1993 and thereafter.[4]

Overall

Since fiscal year 1986, the Medicare extra billing rate has been steadily decreasing. It was 36.6 percent in fiscal year 1986 and had dropped to 29.8 percent in calendar year 1991. During 1992, extra billing dropped to 22.8 percent. This constituted a 23.5 percent reduction from the 1991 rate. See Table 11.[5]

State Analysis

In 1992, with one exception (i.e., an 11.1 percent rate in Pennsylvania), the range of extra billing rates across States was fairly narrow. Excluding Pennsylvania, the rates ranged from 19.4 percent in Vermont to 28.6 percent in Hawaii, with 40 States clustered in the range from 18 percent to 23 percent. The highest extra billing rates were found in Alaska (28.0 percent), Hawaii (28.6 percent), New York (27.3 percent), and Rhode Island (27.4 percent). The lowest rates were in Delaware (19.5 percent), Massachusetts (19.5 percent), Pennsylvania (11.1 percent), and Vermont (19.4 percent). Three of these latter four States (Massachusetts, Pennsylvania, and Vermont) have what amount to state mandatory assignment laws, suggesting that the areas with the lowest extra billing rates are those where there usually is no extra billing.

That pattern does not hold, however, when one examines Rhode Island--another State subject to mandatory assignment in 1992. In Rhode Island, only .5 percent of allowed charges were unassigned, but the extra billing rate for that small proportion of charges was quite high at 27.4 percent. In fact, in Rhode Island, this represented a 27.4 percent increase over that State's 1991 extra billing rate and Rhode Island was the only State that had a 1991 to 1992 increase in its extra billing. Every other State experienced decreases in extra billing rates from 1991 to 1992, despite the fact that all but eight States had reduced Medicare payments per service in 1992. The smallest decrease was in Nebraska (-15.5 percent) and the largest decreases were in Pennsylvania (-47.4 percent) and North Carolina

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[4]In April 1993, the Office of Inspector General, Department of Health and Human Services, issued a report on "Limits on Beneficiary Financial Liability."

[5]Note that while we measure the extra billing rate by examining only unassigned claims, another measure is the ratio of the extra billing amount on unassigned claims to all allowed charges. Rather than 22.8 percent, that proportion is actually only 3 percent.

TABLE 11

Extra Billing Rates For Unassigned Allowed Charges By Nonparticipants, By State

State	1991 Ratio of Extra Billing [1] to Allowed Charges	1992 Ratio of Extra Billing [1] to Allowed Charges	Percent Change 1991 - 1992
Total [2]	29.8	22.8	-23.5 %
Alabama	29.4	22.2	-24.5
Alaska	36.4	28.0	-23.1
Arizona	26.8	21.8	-18.7
Arkansas	29.1	20.8	-28.5
California	31.9	24.6	-22.9
Colorado	31.6	22.0	-30.4
Connecticut	28.1	22.3	-20.6
Delaware	28.4	19.5	-31.3
District of Columbia	32.1	23.3	-27.4
Florida	27.3	21.0	-23.1
Georgia	30.8	23.2	-24.7
Hawaii	38.7	28.8	-26.1
Idaho	29.3	21.5	-26.6
Illinois	29.9	22.8	-23.7
Indiana	27.5	21.0	-23.6
Iowa	28.5	20.7	-27.4
Kansas	24.8	20.3	-18.1
Kentucky	26.9	20.9	-22.3
Louisiana	30.8	21.4	-30.5
Maine	26.3	21.1	-19.8
Maryland	26.8	21.9	-18.3
Massachusetts	26.0	19.5	-25.0
Michigan	27.1	21.3	-21.4
Minnesota	31.3	22.1	-29.4
Mississippi	32.1	25.4	-20.9
Missouri	27.1	21.5	-20.7
Montana	30.1	22.2	-26.2
Nebraska	25.1	21.2	-15.5
Nevada	30.1	24.1	-19.9
New Hampshire	28.6	21.8	-23.6
New Jersey	31.9	23.1	-27.6
New Mexico	29.4	22.7	-22.8
New York	33.4	27.3	-18.3
North Carolina	32.2	21.3	-33.9
North Dakota	31.0	22.4	-27.7
Ohio	29.7	22.2	-25.3
Oklahoma	30.4	22.1	-27.3
Oregon	27.6	22.3	-19.2
Pennsylvania	21.1	11.1	-47.4
Rhode Island	21.5	27.4	27.4
South Carolina	29.5	21.5	-27.1
South Dakota	29.6	21.5	-27.4
Tennessee	29.5	21.5	-27.1
Texas	30.0	23.0	-23.3
Utah	32.5	22.9	-29.5
Vermont	27.0	19.4	-28.1
Virginia	27.9	22.0	-21.1
Washington	29.4	22.4	-23.8
West Virginia	31.5	22.8	-27.6
Wisconsin	26.8	21.2	-20.9
Wyoming	29.2	21.5	-26.4
Puerto Rico/Virgin Islands	24.2	19.7	-18.6

[1] Extra billing is the difference between the submitted charge and the allowed charge for unassigned claims. Excludes unassigned charges for denied services.

[2] Includes unassigned charges for Railroad Retirement Board

Based on summary data from the 1992 National Claims History for physicians' services incurred and processed from January through December 1992.

SOURCE: Bureau of Data Management and Strategy

(-33.9 percent). Nebraska was not among the big losers payment-wise under the fee schedule (1 percent decrease per payment) and Pennsylvania and North Carolina were not among the winners. In fact, the latter were losers at 2 percent and 3 percent reductions per service, respectively. Thus, there was no clear pattern of payment winners reflecting the largest decreases in extra billing and payment losers, the smallest decreases. No regional patterns emerged in terms of extra billing reductions.

Specialty Analysis

In 1992, extra billing for physicians was highest among anesthesiologists, gynecologists, plastic surgeons, and oral surgeons. Extra billing also tended to be high among suppliers paid under the physician fee schedule.[6] See Table 12. While anesthesiologists are among the biggest billers on unassigned claims, it is that group that has had the largest reduction in its proportion of unassigned dollars. Oral surgeons too had a big increase in their share of charges billed on an assigned basis, while at the same time those still billing unassigned were among the highest chargers.

The lowest 1992 extra billing rates were found among dermatologists (19.9 percent), optometrists (8.9 percent), chiropractors (13.7 percent), and podiatrists (17.8 percent). These specialties also tended to have relatively low 1992 increases in their proportion of assigned charges. Their lower assignment rate increases suggest that it is important to them to bill above the Medicare allowance, but below or at the limiting charge.

From 1991 to 1992, all physician specialties, except one, experienced a reduction in their extra billing rates. The only increase was among radiologists, who moved from an extra billing rate of 20.9 percent in 1991 to 22.0 percent in 1992. During 1991, when physicians billed on an unassigned basis for services under the radiology or nuclear medicine fee schedules, they could charge no more than 115 percent of the fee schedule amount. In 1992, when all of those services, as well as others, went to payment under the overall physician fee schedule, the charge limit was 120 percent of the fee schedule amount. Therefore, the radiologists' extra billing increases are undoubtedly the result of the permitted billing limit increasing from 115 percent to

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[6]Suppliers paid under the physician fee schedule are generally not subject to the limiting charge provisions applicable to physician billings.

TABLE 12

Extra Billing Rates For Unassigned Allowed Charges by Nonparticipants, By Specialty

Specialty	Ratio of Extra Billing [1] to Allowed Charges		Percent Change 1991 - 1992
	1991	1992	
All Specialties [2]	29.8	22.8	-23.5 %
Physicians (MDs and DOs)	29.9	23.0	-23.1
Family Practice	26.7	20.1	-24.7
General Practice	26.9	20.0	-25.7
Cardiology	29.8	23.0	-22.8
Dermatology	26.7	19.9	-25.5
Internal Medicine	26.1	20.9	-19.9
Gastroenterology	27.6	22.1	-19.9
Nephrology	32.7	22.4	-31.5
Neurology	31.6	22.4	-29.1
Obstetrics-Gynecology	43.8	33.0	-24.7
Psychiatry	34.9	23.9	-31.5
Pulmonary	28.6	21.2	-25.9
Urology	31.1	23.8	-23.5
Anesthesiology	38.3	31.3	-18.3
Pathology	31.7	22.4	-29.3
Radiology [3]	20.9	22.0	5.3
General Surgery	37.4	26.9	-28.1
Neurosurgery	43.7	28.8	-34.1
Ophthalmology	26.7	20.7	-22.5
Orthopedic Surgery	34.3	25.1	-26.8
Otolaryngology	35.5	25.2	-29.0
Plastic Surgery	55.0	41.6	-24.4
Thoracic Surgery	37.5	27.0	-28.0
Clinic or other group practice	32.8	24.9	-24.1
All other physicians	31.7	22.1	-30.3
Limited License Practitioners (LLPs)	26.0	16.3	-37.3
Optometry	18.4	8.9	-51.6
Chiropractic	25.2	13.7	-45.6
Podiatry	25.6	17.8	-30.5
Oral Surgery	68.5	63.8	-6.9
Total Physicians (MDs, DOs and LLPs)	29.8	22.7	-23.8
Nonphysician Practitioners [4]	32.7	36.3	11.0
Suppliers	41.9	32.5	-22.4
Portable X-Ray Supplier (Independent)	27.4	40.7	48.5
Independent Laboratory	38.2	25.2	-34.0
All Other Suppliers	53.8	43.6	-19.0

[1] Extra billing is the difference between the submitted charge and the allowed charge on unassigned claims. Excludes submitted charges for unassigned services that were denied.

[2] Includes physicians (doctors of medicine (MDs), doctors of osteopathy (DOs), and limited license practitioners (LLPs)), nonphysician practitioners and suppliers

[3] Includes radiation therapy and nuclear medicine specialities.

[4] Includes audiologists, physical therapists, occupational therapists, and psychologists (billing HCPCS 90830). Excludes certified nurse midwives, certified registered nurse anesthetists, nurse practitioners and clinical social workers.

Based on summary data from the 1992 National Claims History for physicians' services incurred and processed from January through December 1991.

SOURCE: Bureau of Data Management and Strategy

120 percent for services which had been under the radiology and nuclear medicine fee schedules.[7]

In addition to radiologists, portable x-ray suppliers also substantially increased their extra billing rate in 1992. In fact, their rate increased by almost 50 percent when it went from 27.4 percent in 1991 to 40.7 percent in 1992. This group is subject to the Federal limiting charge provisions only when they bill for physicians' professional services. They are not subject to those provisions when they bill for the technical or test portion of x-ray services (i.e., the actual taking of the x-ray). Also, as in the case of radiologists, portable x-ray suppliers went from 1991 billing limits of 115 percent to 1992 limits, where applicable, of 120 percent.

The biggest 1992 reductions in extra billing rates were found among psychiatrists, neurosurgeons, optometrists, chiropractors, and podiatrists. Only the last three experienced 1992 payment increases that could account for their relatively large extra billing reductions.

Type of Service Analysis

In 1992, extra billing rates decreased for all types of services except imaging/procedure. See Table 13. For imaging/procedure services, the extra billing rate increased by 14.2 percent. The procedures in that category include invasive imaging procedures such as cardiac catheterizations.

We note that the imaging/procedure type of service category, like all of the others, had a 1992 reduction in the proportion of charges billed on an unassigned basis--i.e., the assignment rate

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[7]Section 1848(g)(2)(B) of the Social Security Act, as amended by P.L. 101-508, section 4118(f)(1)(Q), suggests that the charge limit, in 1992, should have remained at 115 percent for radiology and nuclear medicine fee schedule services. However, the technical amendment made by P.L. 101-508 could be effective for only 1991. In that year, there were services subject to the radiology and nuclear medicine fee schedules, (i.e., subject to section 1834(b) of the Social Security Act), and P.L. 101-508 made it clear that the 115 percent charge limit, applicable to those fee schedules, still applied to those services. However, the aspects of P.L. 101-508 that attempted to apply the radiology and nuclear medicine 115 percent charge limit to those services in 1992 could not be implemented. This was because, in 1992, there were no longer any services subject to the radiology or nuclear medicine fee schedules. In 1992, all of the services at issue were paid for under section 1848 (i.e., under the Medicare physician fee schedule) and consequently all were subject to the same charge limit of 120 percent.

TABLE 13

Extra Billing Rates For Unassigned Allowed Charges By Nonparticipants, By Type of Service

Type of Service [2]	Ratio of Extra Billing [1] to Allowed Charges		Percent Change
	1991	1992	1991 - 1992
Anesthesia	38.6	31.9	-17.4 %
Standard Imaging	24.3	21.6	-11.1
Advanced Imaging	23.3	22.0	-5.6
Echography	33.6	22.1	-34.2
Imaging/Procedure	26.1	29.8	14.2
Office Visits	22.5	19.0	-15.6
Hospital Visits	29.3	21.1	-28.0
Emergency Department Care	44.7	23.8	-46.8
Home/Nursing Home Visits	29.9	19.4	-35.1
Specialist Visits	26.9	18.6	-30.9
Consultations	28.3	20.8	-26.5
Major Procedures General	38.7	28.7	-25.8
Major Cardiovascular Procedures	35.0	26.6	-24.0
Major Orthopedic Procedures	33.8	25.3	-25.1
Eye Procedures - Surgery	28.9	23.0	-20.4
Ambulatory Procedures	41.5	31.0	-25.3
Minor Procedures	34.6	25.1	-27.5
Oncology	26.2	23.1	-11.8
Endoscopy	32.1	24.0	-25.2
Dialysis	41.0	27.8	-32.2
Lab Tests	38.7	29.7	-23.3
Other Tests	31.7	26.7	-15.8
Assistant at Surgery	64.6	44.4	-31.3
Chiropractic	25.1	13.7	-45.4
Total [3]	29.8	22.8	-23.5

[1] Extra billing is the difference between the submitted charge and the allowed charge on unassigned claims. Excludes submitted charges for denied services.

[2] All types of service (TOS) except 'assistant at surgery' are based on procedure code groupings developed by the Urban Institute. See Appendix for additional TOS descriptions. Type of service 'assistant at surgery' based on HCFA type of service code.

[3] Includes data for not otherwise classified CPT codes and HCFA assigned codes.

Based on summary data from the 1992 National Claims History for physicians' services incurred and processed from January through December 1992.

SOURCE: Bureau of Data Management and Strategy

increased. Therefore, in that category, while there were substantial increases in extra billing amounts charged on unassigned claims, there were fewer Medicare dollars paid on an unassigned basis.

Among the type of service categories experiencing extra billing reductions, the smallest reduction was in advanced imaging--which includes computerized axial tomography (CAT) scans and magnetic resonance imaging (MRI) services. The smaller CAT scan and MRI reductions might be attributable to 1992 payment rate decreases for radiologists. The largest reductions were in emergency department care and chiropractic. The latter is consistent with chiropractors experiencing, in 1992, a 12 percent increase in Medicare payments per service.

Implications for Limiting Charge Enforcement

Although, in 1992, the national extra billing rate dropped substantially--i.e., to a rate of 22.8 percent, that level suggests that limiting charge violations are occurring. Perfect limiting charge compliance would yield an extra billing rate of 20 percent or less.

As we discussed in last year's report, HCFA and the Medicare carriers, during 1992, implemented a Comprehensive Limiting Charge Compliance Program. That program involves a claim-by-claim review of all unassigned claims from nonparticipating physicians and requires that carriers issue bi-weekly reports to physicians who exceed the limit. Those reports, which are called Limiting Charge Exception Reports (LCERs), advise physicians of the excess charge and advise them of their responsibility to bill correctly in the future and refund excess receipts to beneficiaries. In August 1992, 12 carriers began issuing LCERs, as part of a pilot arrangement. By early December 1992, all carriers were issuing such reports, with most of those having actually begun in late November. For most carriers, the period being monitored for LCER purposes began on October 1, 1992.

In the middle of December 1992, we also began including limiting charge messages on the Explanation of Medicare Benefits (EOMBs) sent to beneficiaries. The messages advise beneficiaries of when they have been charged more than the limiting charge amount on an unassigned claim and of the physicians responsibility to make refunds.

Thus, while our limiting charge enforcement has been substantially enhanced, those improvements did not occur until late in 1992. Therefore, the impact of our increased efforts can not yet be determined. We do, however, have some limited data from the period ending December 31, 1992. That data include:

- the total number of LCERS issued by each carrier,
- the total allowed charges on the claims identified in the LCERS, and
- the total excess charges (i.e., the charges above the limiting charge levels).

During the limited 1992 period covered by LCERs, carriers issued a total of 183,383 LCERs, involving $69.6 million in allowed charges, and $46.4 million above the limiting charge levels. This essentially means that, for those claims, actual or submitted charges equalled $129.9 million (i.e.,($69.6 million x 120 percent) + $46.4 million). Thus, on average, where there were violations, the submitted charges exceeded the allowed charges by 87 percent, rather than the 20 percent permitted by

the limiting charge. The obvious conclusion is that where there were violations, they were "big" violations.

Our LCER data are not being accumulated by specialty or type of service, but we are able to look at what was going on within particular States. There were six States where, on the LCER reports, the submitted charges exceeded allowed charges by 95 percent or more. Those States were Rhode Island, New York, Louisiana, Missouri, Nevada, and Alaska. Also, billed charges from Puerto Rico and the Virgin Islands exceeded allowed charges by 95 percent. As noted above, we too found Alaska, New York, and Rhode Island to be very high extra billing States--based on our statistics from all unassigned claims, rather than only those on the LCERs.

CHANGES IN PARTICIPATION ENROLLMENT RATES IN 1993

In this section, we examine the extent to which there were participation enrollment rate changes for the 1993 participation period. Each fall, physicians and other practitioners are given the opportunity to decide whether to sign or terminate Medicare participation agreements. Under the terms of those agreements, physicians and practitioners agree not to charge Medicare beneficiaries more than the Medicare allowed amount for any services paid for under Part B of Medicare. A major advantage for physicians who choose to participate is that their Medicare fee schedule amount is 5 percent higher than that of nonparticipating physicians. Also, participating physicians are listed in a Medicare Participating Physician/Supplier Directory that is furnished to senior citizen groups.

Possible influences on physician/practitioner decisionmaking during this past enrollment period were the physician fee schedule payment changes made effective January 1, 1993. On November 25, 1992, Federal Register notices were published which refined relative value units[8] and which established surgical versus nonsurgical update factors for 1993.[9] For 1993, surgical services received an update of 3.1 percent and nonsurgical services received an update of 0.8 percent. This means that, for 1993, the dollar conversion factor used to compute physician fee schedule amounts is $31.962 for surgical services, $31.249 for nonsurgical services, and $14.05 for anesthesia services. During 1992, surgical and nonsurgical services had the same dollar conversion factor of $31.001. Surgical services are those classified under the type of service "surgery" if performed by one of the following "surgical" specialties:

--General surgeon
--Neurological surgeon
--Obstetrician
--Gynecologist
--Ophthalmologist
--Oral surgeon
--Orthopedic surgeon
--Otorhinolaryngologist
--Plastic surgeon
--Proctologist
--Thoracic surgeon
--Urologist
--Podiatrist
--Dermatologist

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[8]Federal Register, Vol. 57, No. 228, November 25, 1992, pp. 55914 et seq.

[9]Ibid., pp. 56168 et seq.

--Hand surgeon
--Multi-specialty clinic

As a result of the relative value unit refinements, effective January 1, 1993, all three primary care specialties--family practice, general practice, and internal medicine--experienced net gains. The largest gainers were psychiatry, neurology, pathology, and chiropractic. Payment losers included gastroenterology, urology, radiology, anesthesiology, neurosurgery, ophthalmology, orthopedic surgery, and plastic surgery.

It appears, therefore, that these two factors (i.e., the update and relative value refinement) could offset each other in terms of payment effect and consequently in terms of affecting enrollment decisionmaking. The refinement tended to reduce relative value units for surgical specialties, but the update favored them. The refinement favored primary care and other specialties providing substantial numbers of visit services, but those specialties received a substantially lower update factor.

No State or geographic redistributions are expected as a result of the recent relative value unit refinement process.

Overall

As indicated in last year's report, participation, as measured by the percent of physicians/practitioners signing agreements, has increased substantially since the beginning of the participation program in 1984. Those rates increased from 30.4 percent in October 1984 to 52.2 percent in January 1992. Effective January 1993, the participation enrollment rate had risen to 59.8 percent. See Table 14.

State Analysis

Compared to the participation enrollment rates for January 1992, 1993 enrollment rates increased in every State. There were 36 States which had increases of over 10 percent and the highest among those was a 130.8 percent increase in Montana. See Table 14.

The State with the lowest 1993 enrollment increase was Massachusetts. Massachusetts had only a 0.4 percent increase in the percent of physicians/practitioners/suppliers signing on as participants. Although there is improvement in that 1993 reflects an increase, it is a very modest one compared to that experienced in most other States. Effective January 1, 1993, Massachusetts had only 50.2 percent of its physicians/ practitioners/suppliers signed on as participants--a figure less than the 59.8 percent national average.

TABLE 14

1993 Physician/Practitioner Enrollment, By State

State	January 1,1992 Participation Percentage	January 1, 1993 Participation Percentage	Percent Change 1992-1993
National	**52.2 %**	**59.8 %**	**14.6 %**
Alabama	83.4	85.1	2.0
Alaska	55.1	60.4	9.6
Arizona	64.5	76.2	18.1
Arkansas	57.8	62.1	7.4
California	62.6	65.9	5.3
Colorado	48.0	55.7	16.0
Connecticut	48.1	55.4	15.2
Delaware	51.9	57.4	10.6
District of Columbia	45.7	50.6	10.7
Florida	41.5	55.6	34.0
Georgia	57.2	74.9	30.9
Hawaii	64.1	75.9	18.4
Idaho	22.9	37.1	62.0
Illinois	50.8	57.6	13.4
Indiana	49.3	55.8	13.2
Iowa	58.8	61.8	5.1
Kansas	70.3	73.2	4.1
Kentucky	64.0	73.6	15.0
Louisiana	44.6	44.0	-1.3
Maine	51.6	52.0	0.8
* Maryland	58.7	72.5	23.5
Massachusetts	50.0	50.2	0.4
Michigan	51.7	58.1	12.4
Minnesota	34.4	44.4	29.1
Mississippi	47.9	53.4	11.5
Missouri	51.8	67.5	30.3
Montana	23.7	54.7	130.8
Nebraska	61.1	70.8	15.9
Nevada	75.4	84.9	12.6
New Hampshire	38.5	43.0	11.7
New Jersey	36.5	42.6	16.7
New Mexico	53.6	66.8	24.6
New York	36.9	40.7	10.3
North Carolina	68.2	72.8	6.7
North Dakota	45.8	55.0	20.1
* Ohio	57.3	76.6	33.7
Oklahoma	44.4	53.9	21.4
Oregon	51.7	59.2	14.5
Pennsylvania	53.0	59.7	12.6
Rhode Island	70.3	80.9	15.1
South Carolina	63.0	67.3	6.8
South Dakota	23.7	31.6	33.3
Tennessee	67.6	70.5	4.3
Texas	52.9	61.3	15.9
Utah	69.5	80.3	15.5
Vermont	54.2	56.5	4.2
Virginia	49.9	52.2	4.6
Washington	53.1	64.7	21.8
* West Virginia	68.4	75.9	11.0
Wisconsin	55.5	66.8	20.4
Wyoming	50.2	53.3	6.2

* Note: Some caution should be exercised in utilizing this table because of some changes in reporting. For example, effective January 1, 1993, Maryland participation enrollees are counted by UPIN number rather than provider number. And effective January 1, 1993, the carrier for Ohio and West Virginia eliminated the use of specialty 70 and now counts members of such clinics individually, under their own specialty, for participation enrollment purposes where as formerly only the overall clinic was counted.

SOURCE: Bureau of Program Operations

This low enrollment rate and low rate of increase in Massachusetts is somewhat surprising since, as a condition of Massachusetts State licensure, physicians must accept the Medicare allowance amount as payment in full for services rendered to Medicare patients. Those who do not sign participation agreements, but comply with the State law, receive only 95 percent of the regular Medicare allowance amount. Essentially, almost half of the physicians in Massachusetts choose not to sign Medicare participation agreements--even though State law requires that they charge in a manner consistent with such an agreement and even though it means a 5 percent reduction in their revenues from Medicare patients.

Physicians like these non-enrollees in Massachusetts have been referred to as de facto participants--i.e., they do not enroll, but they accept assignment in virtually all cases. One earlier study has found that most de facto participants have a philosophical belief that physicians, and not the government, should set their fees. That study points out that this appears to be a bit contradictory when these physicians do in fact routinely cap their charge at the "government" allowance amount. See "Trends in Medicare Participation and Assignment Rates, 1984-1987," February 5, 1988, Rosenbach, Harrow, and Mitchell, p. 5-3, Research supported by HHS Contract No. 100-86-0023 cosponsored by the Assistant Secretary for Planning and Evaluation and HCFA.

It is important to note that this examination of Massachusetts' nonparticipants is pertinent for only a small proportion of the Medicare allowed charges in that State. While nonparticipants are half of the physician population in Massachusetts, they account for only 7 percent of the Medicare allowed dollars paid in that State. Thus, 93 percent of Massachusetts' allowed charges are paid to participants and, therefore, at the full allowance amount. Of course, beneficiary liability--i.e., the 20 percent coinsurance--is lower for the 7 percent and higher for the 93 percent.

The Massachusetts pattern in not repeated in the other two States with absolute (i.e., non-means test) mandatory assignment laws. Like Massachusetts, Pennsylvania, and Rhode Island have over 95 percent of their allowed charges billed by participants. However, in Rhode Island, that population of participants includes over 80 percent of the States' physicians. Clearly, in contrast to Massachusetts, a Rhode Island beneficiary is able to choose from a substantially larger proportion of physicians actively involved in treating Medicare patients. Moreover, the current Rhode Island enrollment rate represents an increase, from 1992 to 1993, of 15.1 percent. In Pennsylvania, nearly 60 percent of physicians are participants and this represents a 12.6 percent increase from 1992 to 1993.

Also of interest is the recent Ohio experience. At the end of 1992, that State passed a means-related mandatory assignment law. For the 1993 participation period, Ohio enrollment rose by 33.7 percent. The result was that, effective January 1, 1993, Ohio went from 57 percent of its physicians/practitioners/ suppliers being enrolled as Medicare participants to almost 77 percent. Contrary to the Massachusetts experience, enactment of the Ohio statute appears to have substantially increased the numbers of physicians choosing to participate in Medicare.

Specialty Analysis

Participation enrollment increased, effective January 1, 1993, for every specialty except one. See Table 15.

Enrollment decreased--by 1.9 percent--for multispecialty clinics or group practices--Medicare specialty number 70. Note, however, that, for this specialty, the participation enrollment rate did not go down from December 31, 1992 to January 1, 1993. In fact, at that point, the rate went up from 72.7 percent to 75.5 percent. As noted in last year's report, on January 1, 1992, the participation enrollment rate for specialty 70 was 77 percent. Therefore, it was during the year, i.e., during 1992, that the participation rate went down from 77 percent to 72.2 percent and the effect of the 1993 enrollment was to actually bring the rate back up to 75.5 percent. Thus, it was not the 1993 enrollment that reduced the participation rate for specialty 70. It was events that occurred during 1992, the major event being the recognition of 17 new physician specialties by Medicare. As explained in Appendix 1, when those 17 new specialties were added, physicians were given the opportunity to change their specialty designation. Use of the multispecialty clinic or group practice specialty was discouraged, given the emphasis on identifying individual providers. We believe that the net effect of changes into and out of specialty 70--primarily as a result of the "new" specialty selection opportunity--was the reduction of the participation enrollment rate for that specialty. This would, of course, mean that, during 1992, specialty 70 lost more participating than nonparticipating entities, not as a result of enrollment changes, but instead as a result of physicians re-designating their specialty category.[10]

Moreover, this analysis of specialty 70 highlights the fact that, for a variety of reasons, physician movements into and out of all specialties occur during every year. Therefore, in our comparisons, we are not actually measuring change that is purely the result of the enrollment process. Instead, the change measured, from one January "snapshot" date to the next, is the cumulative result of everything that happens during the year--e.g., physician movement in response to new specialties, new physicians signing on into various specialties, older physicians

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[10]Early in 1992, consistent with our instructions, Medicare carriers sent materials to physicians to give them the opportunity to redesignate a specialty, in view of the new ones that we had recently recognized. An updated list of physician specialties was included in that material and specialty 70 was not included on that list. Therefore, many entities undoubtedly dropped the use of that specialty for another--assuming that specialty 70, multispecialty clinic, was no longer permitted under Medicare.

TABLE 15

1993 Physician/Practitioner Enrollment, By Specialty

Specialty	January 1, 1992 Participation Percentage	January 1, 1993 Participation Percentage	Percent Change 1992-1993
Physicians (MDs and DOs)	**59.0**	**67.2**	**13.9 %**
General Practice	48.0	57.5	19.8
General Surgery	66.3	74.3	12.1
Otolaryngology	57.0	66.2	16.1
Anesthesiology	49.3	64.6	31.0
Cardiology	72.0	78.7	9.3
Dermatology	61.6	69.8	13.3
Family Practice	57.7	67.0	16.1
Internal Medicine	57.8	67.4	16.6
Neurology	63.8	71.8	12.5
Obstetrics-Gynecology	58.0	65.7	13.3
Ophthalmology	66.1	73.2	10.7
Orthopedic Surgery	65.5	74.9	14.4
Pathology	65.8	73.3	11.4
Psychiatry	48.8	53.5	9.6
Radiology	68.2	75.0	10.0
Urology	61.7	71.8	16.4
Nephrology	76.3	82.4	8.0
Clinic or Other Group Practice	77.0	75.5	-1.9
All Other Physicians	52.1	63.0	20.9
Limited License Practitioners (LLPs)	**34.1**	**38.6**	**13.2**
Chiropractic	31.4	35.6	13.4
Podiatry	64.2	70.9	10.4
Optometry	59.0	62.7	6.3
Oral Surgery	11.0	14.1	28.2
Total Physicians (MDs, DOs and LLPs)	**54.2**	**62.0**	**14.4**
Nonphysician Practitioners	**35.0**	**44.0**	**25.7**
Certified Nurse-Midwife	40.7	51.0	25.3
Certified Registered Nurse Anesthetist	31.3	43.8	39.9
Physical Therapist (independent)	44.3	50.1	13.1
All Other Non-physician Practitioners [2]	34.9	43.4	24.4
Suppliers	**23.7**	**28.8**	**21.5**
Independent Laboratory	52.4	55.4	5.7
Durable Medical Equipment Supplies	24.2	30.2	24.8
Ambulance Service Supplier	34.4	36.4	5.8
All Other Suppliers [3]	18.2	24.8	36.3

[1] Based on the number of participating physicians, nonphysician practitioners, and suppliers.

[2] Includes audiologists, psychologists, clinical social workers and occupational therapists.

[3] Includes suppliers of orthotics and prosthetics, and portable x-ray suppliers.

SOURCE: Bureau of Program Operations

retiring from various specialties, and of course the fall enrollment process. It is only the enrollment process that changes the participation status of a physician entity, but the enrollment rate in any given specialty can change all during the year, depending upon the participation status of physicians who leave or enter the specialty.

By far, anesthesiologists had the largest 1993 increase in their participation enrollment. They had an increase of 31 percent--despite the payment reductions they experienced under refinement as well as their "nonsurgical" update factor. Oral surgeons were close behind with a 28.2 percent increase. See Table 15. Out-of-the-ordinary increases were not observed among the refinement process winners, but, again, these specialties--neurology, psychiatry, pathology, and chiropractic--were also update "losers."

The lowest physician increase was 8.0 percent and that was the increase for nephrologists. It should be noted, however, that, for 1993, nephrologists have the highest participation enrollment rate. Over 82 percent of nephrologists have signed participation agreements with Medicare.

IMPLICATIONS OF FINDINGS/PLAN TO ADDRESS PROBLEMS

Under the first year of the physician fee schedule, we found no substantial decreases in Medicare assignment rates or proportions of charges billed by participating physicians. Similarly, we found no substantial increases in Medicare extra billing rates among nonparticipating physicians. Consequently, no plan to address problems associated with such increases or decreases is submitted as part of this report.

APPENDIX 1

1992 SPECIALTY CHANGES AND CROSSWALK

During calendar year 1992, the Health Care Financing Administration recognized 17 new physician specialties. The existence of the new specialties was announced to physicians and they were given the opportunity to be listed under one of the new specialty designations.

In order to compare assignment, participation, and extra billing changes--by specialty--from 1991 to 1992, we have crosswalked 1992 data from the new specialties back into one or more of the old specialties. We established this crosswalk based on our review of detailed data from one State on physicians' choices in making specialty changes (i.e., the State of Georgia) and based on judgments provided HCFA physician staff.

The new specialties are as follows:

Specialty	No. of MDs/DOs	1992 Allowed Charges	Crosswalked to
46 Endocrinology	1194	$66,391,207	Internal Medicine (IM) 11
66 Rheumatology	1231	$96,419,647	IM 11
76 Periph. Vascular Disease	167	$13,079,132	Gen Surg (GS) 02, IM 11
77 Vascular Surgery	575	$116,426,470	GS 02
78 Cardiac Surgery	524	$135,361,384	Thoracic Surg 33
79 Addiction Medicine	91	$4,563,962	IM 11, Psych 26, GP 01
81 Critical Care	353	$21,532,627	Anes 05, IM 11, GS 02
82 Hematology	221	$29,726,735	All Other Physicians
83 Hematology/Oncology	1951	$219,268,819	IM 11
84 Preventive Medicine	139	$1,444,335	GP 01, Fam Prac 08, IM 11
85 Maxillofacial Surgery	642	$3,458,222	Oral Surg 19
86 Neuropsychiatry	143	$5,650,530	Psych 26
90 Medical Oncology	625	$54,546,434	IM 11
91 Surgical Oncology	164	$10,294,115	GS 02
92 Radiation Oncology	944	$207,959,337	Radiology 30
93 Emergency Medicine	7922	$164,321,174	GP 01, Fam Prac 08, IM 11
94 Interventional Radiology	136	$17,208,866	Radiology 30
	17022	$1,167,650,996	

The number of physicians identified in each was obtained from a unique physician identification number file. The numbers listed were as of January 1, 1993. The third column represents the 1992 allowed charges, from the National Claims History, associated with each of the new specialties. The fourth column lists the old specialty or specialties to which we have crosswalked the new specialty data. Where more than one specialty is listed, the data have been evenly distributed across all of the specialties. Note that we "dumped" the data from specialty 82, hematology, into the "all other" category. We did this because, for the first half of 1992, that specialty number was assigned to "ophthalmology, cataract specialty" and, for the latter part of the year, to hematology. This made it difficult to identify the "old" specialty to which we should crosswalk the data from the "new" specialty 82.

In a future year, we will start including the new specialties in our analyses for these annual reports. We have chosen not to prepare "rebased" 1992 assignment and extra billing data tables for this purpose because there are a number of 1992 "data" problems associated with the new specialties. We are advised, for example, that carriers were not consistent in their start-up dates for implementation of the new specialties. It may be that the first reliable National Claims History data for the new specialties will not exist until calendar year 1993. We do, however, include the new specialties in a rebased 1993 table on the numbers/percentages of physicians and practitioners signing up for 1993 participation. Although we crosswalked the new specialty data back into old specialties for purposes of our 1992 versus 1993 participation enrollment comparison, we are also including, as part of this Appendix, a rebased 1993 table, so that, for the participation period beginning on January 1, 1994, comparisons which reflect the new specialties can be made.

REBASED PHYSICIAN SPECIALTY TABLE FOR 1994 PHYSICIAN PARTICIPATION REPORT

Medicare Percent of Participating Physicians, Practitioners and Suppliers

SPECIALTY	Participation Percentage		Percent Change
	January 1, 1993	January 1, 1994	
Physicians (MDs and DOs)	67.2		
General Practice	55.1		
General Surgery	73.9		
Otolaryngology	66.2		
Anesthesiology	64.6		
Cardiology	78.7		
Dermatology	69.8		
Family Practice	66.1		
Internal Medicine	66.4		
Neurology	71.8		
Obstetrics-Gynecology	65.7		
Ophthalmology	73.2		
Orthopedic Surgery	74.9		
Pathology	73.3		
Psychiatry	53.5		
Radiology	74.7		
Urology	71.8		
Nephrology	82.4		
Clinic or Other Group Practice	75.5		
* Gastroenterology	78.8		
* Pulmonary	78.7		
* Neurosurgery	72.1		
* Plastic Surgery	71.3		
* Thoracic Surgery	79.0		
* Rheumatology	68.0		
* Vascular Surgery	85.0		
* Cardiac Surgery	81.1		
* Hematology/Oncology	76.0		
* Radiation Oncology	81.8		
* Emergency Medicine	78.6		
All Other Physicians	54.4		
Limited License Practitioners (LLPs)	38.6		
Chiropractic	35.6		
Podiatry	70.9		
Optometry	62.7		
Oral Surgery	14.1		
Total Physicians (MDs, DOs and LLPs)	62.0		
Nonphysician Practitioners	44.0		
Certified Nurse-Midwife	51.0		
Certified Registered Nurse Anesthetist	43.8		
Physical Therapist (Independent)	50.1		
All Other Non-physician Practitioners	43.4		
Suppliers	28.8		
Independent Laboratory	55.4		
Durable Medical Equipment Supplies	30.2		
Ambulance Service Supplier	36.4		
All Other Suppliers	24.8		
All Specialties	55.5		

* - INDICATES SPECIALTIES TO BE ADDED TO 1994 TABLE (SOME OF THESE ARE NOT NEW SPECIALTIES)

APPENDIX 2

Major Type of Service Groups for Procedures Covered by the Medicare Physician Fee Schedule Extracted from the Urban Institute's Classification of the HCFA Common Procedure Coding System

Anesthesia
Chiropractic
Standard Imaging
- Standard Imaging - Chest
- Standard Imaging - Musculoskeletal
- Standard Imaging - Breast
- Standard Imaging - Contrast Gastrointestinal Exam
- Standard Imaging - Nuclear Medicine
- Standard Imaging - Other

Advanced Imaging
- Advanced Imaging - Computerized Axial Tomography (CAT)- Head
- Advanced Imaging - Computerized Axial Tomography (CAT)-Other
- Advanced Imaging - Magnetic Resonance Imaging (MRI)- Brain
- Advanced Imaging - Magnetic Resonance Imaging (MRI)- Other

Echography
- Echography - Eye
- Echography - Abdomen/Pelvis
- Echography - Heart
- Echography - Carotid Arteries
- Echography - Prostate, Transrectal
- Echography - Other

Imaging/Procedure
- Imaging/Procedure - Heart, Including Cardiac Catherization
- Imaging/Procedure - Other

Office Visits
- Office Visits - New
- Office Visits - Established

Hospital Visits
- Hospital Visit - Initial
- Hospital Visit - Subsequent
- Hospital Visit - Critical Care

Emergency Department Care
- Emergency Department Visit

Home/Nursing Home Visits
- Home Visit
- Nursing Home Visit

Specialist Evaluation & Management
- Specialist - Pathology
- Specialist - Psychiatry
- Specialist - Ophthalmology
- Specialist - Other

Consultations
Major Procedures General
- Major Procedure - Breast
- Major Procedure - Colectomy
- Major Procedure - Cholecystectomy

- Major Procedure - Transurethral Resection of Prostate (TURP)
- Major Procedure - Hysterectomy
- Major Procedure - Exploration/Decompression/Excision Disks
- Major Procedure - Other

Major Cardiovascular Procedures

- Major Cardiovascular Procedures - Coronary Artery Bypass (CABG)
- Major Cardiovascular Procedures - Aneurysm Repair
- Major Cardiovascular Procedures - Thromboendarterectomy
- Major Cardiovascular Procedures - Coronary Angioplasty
- Major Cardiovascular Procedures - Pacemaker Insertion
- Major Cardiovascular Procedures - Other

Major Orthopedic Procedures

- Major Orthopedic Procedures - Hip Fracture Repair
- Major Orthopedic Procedures - Hip Replacement
- Major Orthopedic Procedures - Knee Replacement
- Major Orthopedic Procedures - Other

Eye Procedures - Surgery

- Eye Procedures - Corneal Transplant
- Eye Procedures - Cataract Removal/Lens Insertion
- Eye Procedures - Retinal Detachment
- Eye Procedures - Treatment of Retinal Lesions
- Eye Procedures - Other

Ambulatory Procedures

- Ambulatory Procedures - Skin
- Ambulatory Procedures - Musculoskeletal
- Ambulatory Procedures - Inguinal Hernia Repair
- Ambulatory Procedures - Lithotripsy
- Ambulatory Procedures - Other

Minor Procedures

- Minor Procedures - Skin
- Minor Procedures - Musculoskeletal
- Minor Procedures - Other

Oncology

- Oncology - Radiation Therapy
- Oncology - Other

Endoscopy

- Endoscopy - Arthroscopy
- Endoscopy - Upper Gastrointestinal Exam (G.I.)
- Endoscopy - Sigmoidoscopy
- Endoscopy - Colonoscopy
- Endoscopy - Cystoscopy
- Endoscopy - Bronchoscopy
- Endoscopy - Laparoscopic Cholecystectomy
- Endoscopy - Laryngoscopy
- Endoscopy - Other

Dialysis

Laboratory Tests (subject to the physician fee schedule)

Other Tests

- Other Tests - Electrocardiograms
- Other Tests - Cardiovascular Stress Tests
- Other Tests - EKG Monitoring
- Other Tests - Other

Exceptions/Unclassified - Current Procedural Terminology (CPT) Codes

- Not Otherwise Classified CPT Codes

Exceptions/Unclassified - ALPHA Codes
Not Otherwise Classified HCFA Assigned Codes

APPENDIX 3

Assignment and Extra Billing Rates By Age, Race, and Sex

Using 1992 data, we reviewed assignment and extra billing differences by age, race, and sex. For those who are Medicare enrollees based on age eligibility, the older enrollees had higher Medicare assignment rates. The proportion of Medicare allowed charges billed on an assignment-related basis was highest for beneficiaries who were 85 years of age or older. The trend reversed for those who are Medicare enrollees based on disability or End-Stage Renal Disease status. For both of those groups, the younger enrollees had higher Medicare assignment rates. For all eligibility categories, the extra billing rates on unassigned claims were highest for the youngest beneficiaries.

Medicare beneficiaries who are black have more allowed charges billed on an assignment-related basis than white beneficiaries, but on unassigned claims, they experience a higher extra billing rate. Female beneficiaries have a higher assignment rate than male beneficiaries and they have a lower extra billing rate on unassigned claims. See the table included as part of this Appendix.

1992 National Summary by Age, Race and Sex

Characteristics	Assignment Rate	Nonparticipating Physicians/Practitioners Unassigned Services Ratio of Extra Billing Charges to Total Allowed Charges
All Persons	86.8 % *	23.5 *
Male	86.5	23.9
Female	87.1	23.2
White	85.7	23.4
Black	96.6	24.4
Other	86.4	25.5
Unknown Race	92.2	25.2
Aged (MSC 10)	85.9	23.3
65 - 74 YEARS	85.1	23.7
75 - 84 YEARS	86.1	23.0
85 YEARS & OVER	88.3	22.9
Disabled (MSC 20)	94.2	27.7
UNDER 45 YEARS	96.6	30.9
45 - 54 YEARS	94.9	29.0
55 - 64 YEARS	92.6	26.4
ESRD (MSC 11,21,31)	97.0	29.4
UNDER 25 YEARS	98.9	38.7
25 - 44 YEARS	98.1	33.1
45 - 64 YEARS	97.4	32.2
65 AND OVER	96.2	27.3

* Note: These totals differ slightly (i.e., less than 1%) from data presented elsewhere in the report because they are derived from a different data collection.

Based on line item quarterly data from the 1992 National Claims History for physicians' services incurred and processed from January through December 1992.

SOURCE: Bureau of Data Management and Strategy